CHILD'S REGISTRATION AND HISTORY

NAME_____ AGE_____ BIRTH DATE _____ Gender _____

ADDRESS_____ PHONE _____

STREET CITY STATE ZIP

PARENT _____ SOC. # _____ BIRTH DATE _____

ADDRESS (if different) _____ PHONE _____

PARENT _____ SOC. # _____ BIRTH DATE _____

ADDRESS (if different) _____

PHONE _____

DENTAL INS. CARRIER _____

REFERRED BY: _____

1. Is this patient taking any medicine now? _____
2. Is this patient under treatment by a physician? _____
3. Has this patient ever been seriously sick/hospitalized? _____
4. Have you ever been told this patient has a heart murmur? _____
5. Does this patient have asthma or hay fever? _____
6. Does this patient have hives or skin rash? _____
7. Is this patient physically, mentally, or emotionally impaired? _____
8. Has this patient ever had a history of the following?

- € Rheumatic Fever
- € Cancer/Tumors
- € Jaundice (yellow skin/ hepatitis)
- € Scarlet Fever
- € AIDS/HIV Positive
- € Kidney or Liver problems
- € Diabetes
- € Tuberculosis
- € Bleeding/Blood Disorders
- € Measles
- € Congenital Birth Defects
- € Endocrine Disorders
- € Epilepsy/seizures
- € Prosthetic Joint
- € Radiation/Chemotherapy
- € Respiratory Problems
- € Asthma
- € Other (please list) _____
- € Heart Disorders (please explain) _____

9. Has this patient ever experienced an unusual reaction or allergy to any of the following?

- € Penicillin
- € Sulfonamides (sulfa)
- € Dental Anesthetics
- € Codeine
- € Sulfites (Food Preservatives)
- € Latex
- € Ibuprofen
- € Tylenol
- € Other (please list) _____

10. When this patient scratches or cuts themself, has prolonged bleeding been a prob € Yes € No
11. Is this patient receiving fluoride tablets or drops? € Yes € No
12. Has this patient had any difficulty accepting dental treatment previously? Do you anticipate any difficulty? € Yes € No
13. Has this patient had any injuries to mouth, teeth or head? € Yes € No
14. Does this patient have any oral habits (thumb sucking, mouth breathing, pacifiers, € No
15. Approximate date of last dental visit _____ € No

PAYMENT IS REQUIRED WHEN SERVICES ARE RENDERED, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. PLEASE GIVE US 24 HOURS NOTICE IN CANCELLING AN APPOINTMENT OR A FEE OF $50.00 MAY BE ASSESSED TO YOUR ACCOUNT. THANK YOU

Parent or Guardian_____ Relationship to Patient

_____

Signature

Date _____