Date:

Patient Registration

Please Print

Patient's Name _____ Nickname _____ Birthdate _____ Sex _____

Patient's Address _____ Home Phone _____
Street City State Zip

Whom May We Thank For Referring You _____

What is Your Child's Favorite Sport _____ Favorite Toy _____

Favorite Hobby _____ Favorite Person _____ Favorite Fictional Character _____

Child's School _____ Grade _____

Father's Name _____ Mother's Name _____

Address (If Different Than Above) _____

Father's Employer _____ Social Security # _____ Business Phone _____

Mother's Employer _____ Social Security# _____ Business Phone _____

For Patients Covered by Insurance/Medicaid

Subscriber's Name _____ Birthdate _____ Social Security # _____

Subscriber's Employer _____ Business Address _____

Name of Ins. Co. You Mail Forms To _____

Group # _____ Employer # or ID # _____

Secondary Insurance

Subscriber's Name _____ Birthdate _____ Social Security # _____

Subscriber's Employer _____ Business Address _____

Name of Ins. Co. You Mail Forms to _____

Group # _____ Employer # or ID # _____

Dental History

Date of last visit to a dentist _____

For what service _____

	YES	NO
Has child complained about dental problems	☐	☐
Any unhappy dental experiences	☐	☐
Any injuries to mouth - teeth - head	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, etc.	☐	☐
Any unusual speech habit	☐	☐
Any lost teeth	☐	☐
Have missing teeth been replaced	☐	☐
Orthodontic appliances, worn or ever been	☐	☐

	YES	NO
Does your child brush teeth daily	☐	☐
Do you assist child with tooth brushing	☐	☐
How often		
Is dental floss used	☐	☐
How often		
Are disclosing tablets used	☐	☐
Is flouride taken in any form	☐	☐

Child's attitude to dentistry _____

Do you desire complete dental services for your child _____ ☐ ☐

Summary (for doctor's use) _____

HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO
Is child under care of physician now _____	☐	☐
Is child receiving any medication or drugs _____	☐	☐
Is there excessive bleeding when cut _____	☐	☐
Has child ever been hospitalized _____	☐	☐
Has child ever had surgery _____	☐	☐
Is there any allergy to penicillin or other drugs _____	☐	☐
Are there other allergies: food – pollen – animals – dust – other	☐	☐

	YES	NO
Does child have good physical coordination _____	☐	☐
Are there any emotional problems _____	☐	☐

Summary (for doctor's use) _____

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

_____ Anemia	_____ Chronic Sinus	_____ Hearing	_____ Malignancies	_____ Rheumatic Fever
_____ Asthma	_____ Convulsions	_____ Heart	_____ Mastoid	_____ Thyroid
_____ Bladder	_____ Diabetes	_____ HIV	_____ Measles	_____ Tuberculosis
_____ Cerebral Palsy	_____ Epilepsy	_____ Kidney	_____ Mononucleosis	_____ Other
_____ Chicken Pox	_____ Fainting	_____ Liver	_____ Mumps	

SUMMMARY: (for doctor's use)

Please describe any current medical treatement including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

_____

_____

_____

	YES	NO
May we request release of your child's medical records for our reference? _____	☐	☐

This information was discussed with and given by _____

Authorized Signature _____