

Welcome To Our Office

Child Registration

Name _____ Nickname _____ Sex ____
Address _____ Birthday _____ School _____ Grade ____
City _____ State ____ Zip _____ Home Phone _____
E-Mail _____

Father's Name _____ Address _____ Phone _____
Birthday _____ SSN _____ Cell Phone _____
Employer _____ Address _____ Phone _____

Mother's Name _____ Address _____ Phone _____
Birthday _____ SSN _____ Cell Phone _____
Employer _____ Address _____ Phone _____

Other Family Members

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is Your Child's Favorite

Sport _____ Toy _____ Hobby _____ Person _____
Fictional Character _____ Other _____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name _____ Relationship to Child _____
Address _____ Home Phone _____
Employer _____ Work Phone _____
E-Mail _____ Cell Phone _____

Whom may we thank for referring you? _____

Do you have Dental Insurance? (Y N)

In case of emergency who should we contact? _____ Phone _____

CHILD MEDICAL HISTORY

Name _____

What would you like us to do for you today? _____

Physician _____ Phone # _____

Date of last physical _____

Is child under the care of a physician? (Y N) For what ? _____

Is child receiving any medications? (Y N) List _____

Does child have any allergies? _____ Food,Pollen,Animals, Other? _____

Does child bleed excessively when cut? (Y N)

HAS CHILD HISTORY OF , OR DIFFICULTY WITH ANY OF THE FOLLOWING ?

Rheumatic Fever __ , Asthma __ , Radiation Treatments __ , HIV __ , Heart Problems __ ,
Lung Disease __ , Abnormal Blood Pressure __ , Heart Murmur __ , Epilepsy __ ,
Circulatory Problems __ , Hepatitis __ , Stroke __ , Jaundice __ , Cancer __ ,
Anemia __ , Kidney Disease __

DENTAL HISTORY

Date of Last Dental Visit _____ For What? _____

Name of Previous Dentist _____ Address _____

Has Child Mentioned Any Dental Problems ? _____

Has Child Had Any Unhappy Dental Experiences? _____

Has Child Had Any Injurys To Teeth or Mouth? _____

Does Child Have any Mouth Habits? (thumb suck,nail bite,etc.)

Has Child Ever Been To An Orthodontist? _____

Has Anyone In Childs Family Had or Have Braces? _____

Does eather Parent Wear Dentures? _____

Does Child Brush Daily? (Y N) Do You Help? (Y N)

Do You Have Any Specific Concerns About Your Childs Teeth and/or Mouth? _____

Parent or Guardian's Signiture _____ Date _____