

# Patient Registration

Child's Full Name \_\_\_\_\_ Birth Date: \_\_\_\_\_

Child is Called: \_\_\_\_\_ Child's Social Security Number: \_\_\_\_\_ Circle One: Male Female

## Social History

Please circle any of the following that describes your child:

Advanced	Normal	Slow learner	Compulsive	Moody	Shy
Cooperative	Temper	High-strung	Sickly	Spoiled	Suspicious
Fearful	Healthy	Friendly	Defiant	Active	

What or who are your child's friends, hobbies or special interests? \_\_\_\_\_

School / Daycare: \_\_\_\_\_ Grade: \_\_\_\_\_

Child lives with (Please circle): Father Mother Other: \_\_\_\_\_

## Medical History

Child's Physician: \_\_\_\_\_ Last physical exam? \_\_\_\_\_

Any hospitalizations (since birth? No Yes \_\_\_\_\_

Is your child currently taking any medicine? No Yes \_\_\_\_\_

Are your child's immunizations up to date? Yes No \_\_\_\_\_

Does your child have any allergies (food, medicine, latex, hay fever, etc. No Yes \_\_\_\_\_

Does your child have, or has your child ever had, any of the following (please circle Yes or No for each one):

Heart Disease	Yes No	Seizures	Yes No	Snoring	Yes No
Oral Ulcers	Yes No	Pregnancy	Yes No	Stomach Problems	Yes No
Liver Disease	Yes No	Fainting, Dizziness or Headaches	Yes No	Acid reflux	Yes No
Diabetes	Yes No	Hearing or Speech Problems	Yes No	Learning problems	Yes No
Asthma	Yes No	Immune Deficiency	Yes No	Hyperactivity / ADD	Yes No
HIV	Yes No	Kidney Disease	Yes No	Cancer	Yes No
Tuberculosis	Yes No	AIDS	Yes No	Rheumatic Fever	Yes No
Emotional Problems	Yes No	Chemotherapy	Yes No	Bleeding Problems	Yes No
Anemia	Yes No	Hepatitis	Yes No	Pneumonia	Yes No
Bladder Infections	Yes No	Thyroid Problems	Yes No	Autism	Yes No
High Blood Pressure	Yes No	Shortness of Breath	Yes No	Heart Murmur	Yes No

Are there any medical problems not noted above? No Yes \_\_\_\_\_

Has there ever been a concern by you, or your child's physician, about your child's development? No Yes \_\_\_\_\_

**Over, Please!**

Dental History

Is this your child's first visit to the dentist? Yes No Previous Dentist \_\_\_\_\_

Has your child had any unfavorable experiences in a dental or medical office? No Yes \_\_\_\_\_

How do you think your child will react to dental treatment? \_\_\_\_\_

Does your child have, or have a history of, any of the following (circle the ones that apply):

- |                   |                                  |              |                       |
|-------------------|----------------------------------|--------------|-----------------------|
| Toothache         | Speech Difficulties              | Lip Biting   | Injury to teeth       |
| Grinding of teeth | Popping, pain or clicking in jaw | Cleft Palate | Cavities              |
| Mouth Ulcers      | Fever blisters                   | Pacifier     | Thumb or finger habit |
| Bad breath        | Injuries to mouth or head        | Tobacco use  | Orthodontics          |
| Snoring           |                                  |              |                       |

Type of water at home: well spring city filtered \_\_\_\_\_

Does your child take fluoride supplements or at-home treatments? No Yes \_\_\_\_\_

Do you have any special concerns about your child's dental health? \_\_\_\_\_

Parents' Dental Health (Circle all that apply)

Father: Regular checkups      lots of problems in the past      currently has dental problems      braces  
    currently has good dental health      has had bad experiences with the dentist

Mother: Regular checkups      lots of problems in the past      currently has dental problems      braces  
    currently has good dental health      has had bad experiences with the dentist

I understand that the information requested above is necessary to provide my child with dental care in a safe and efficient manner. I have understood each question and have completed these two pages accurately to the best of my knowledge.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Updates

(To be filled in at future appointments)  
 Has there been any change in your child's health since you last completed this form? NO YES \_\_\_\_\_

Has any information on this form changed NO YES \_\_\_\_\_

Date: \_\_\_\_\_ Signed: \_\_\_\_\_ Relation to Patient \_\_\_\_\_

(To be filled in at future appointments)  
 Has there been any change in your child's health since you last completed this form? NO YES \_\_\_\_\_

Has any information on this form changed NO YES \_\_\_\_\_

Date: \_\_\_\_\_ Signed: \_\_\_\_\_ Relation to Patient \_\_\_\_\_