child registration & health history questionnaire

You, as a parent, want to help your child to good oral health. Modern science is making many important contributions to better oral health, but the individual must still take the major responsibility for the care of his/her own mouth. You can teach your child to do so. With proper personal and professional care, your child may keep his/her teeth all his life.

DATE _____

CHILD'S NAME _____ DATE OF BIRTH _____

SCHOOL _____ GRADE _____

RESIDENCE _____

CITY _____ STATE _____ ZIP _____

FATHER'S NAME _____

ADDRESS _____ HOW LONG? _____

HOME PHONE /

EMPLOYED BY _____ BUSINESS PHONE _____

MOTHER'S NAME _____

ADDRESS _____ HOW LONG? _____

HOME PHONE /

EMPLOYED BY _____ BUSINESS PHONE _____

ARE YOU ASSOCIATED WITH A DENTAL INSURANCE PLAN? ___ NAME OF INSURANCE COMPANY _____

POLICY # _____

_____ UNION (LOCAL #) _____ UNION HEAD _____

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT _____

_____

ANY BROTHERS OR SISTERS? _____ LIST AGES _____

IS THIS YOUR CHILD'S FIRST DENTAL EXPERIENCE? _____

WHAT IS THE CHILD'S ATTITUDE TOWARDS THIS VISIT?

_____

_____

_____

COMMENTS: _____

_____

_____

_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

THANK YOU

FORM 115463 ITEM 8101

LAST NAME _____ FIRST NAME _____ DATE OF EXAM _____

MEDICAL HEALTH HISTORY

General health (Please check):

☐ excellent ☐ good ☐ fair ☐ poor

Who is child's physician?

Address?

When did child have last complete physical examination?

Is child treated for anything now?

Did child ever have (Please check):

☐ Kidney disease
☐ Diabetes
☐ Rheumatic fever
☐ Hepatitis
☐ Liver disease
☐ Tuberculosis
☐ Other
☐ Anemia
☐ Asthma
☐ Heart Trouble
☐ Epilepsy / convulsions
☐ Speech impediment
☐ Hearing problem

Is child allergic to (Please check):

☐ Penicillin ☐ Codeine ☐ Novocaine ☐ Other

Is child taking any medications now?

If so, what?

Does child have any allergies?

Is child subject to prolonged bleeding?

Does child have any emotional problems?

I VERIFY THE ABOVE AND GIVE MY CONSENT FOR TREATMENT

PARENT OR GUARDIAN'S SIGNATURE

DENTAL HEALTH HISTORY - CHILD

Date of last dental exam

What concerns you most about your child's dental health?

Does your child ever have dental pain? If so, when?

Did child ever have a negative dental experience?

Discuss

Mouth habits: ☐ Thumb sucking ☐ Mouth breathing ☐ Bottle nursing

Has the child had teeth removed?

Has child had orthodontic treatment?

Does your child have a "sweet" tooth?

How often does your child brush?

Floss?

Has child received any fluoride treatment?

☐ pill/vitamins ☐ topical ☐ water

Are you happy with the appearance of child's teeth?

Has anyone explained the importance of primary teeth?