Dental Solutions
A Partnership In Health

Child's Registration & Health History Questionaire

CHILD'S NAME_____ DATE OF BIRTH__/__/____ DATE__/__/____
SCHOOL_____ GRADE_____
RESIDENCE_____ CITY_____ STATE_____ ZIP_____
FATHER'S NAME_____ ADDRESS_____
EMPLOYED BY_____ PHONE___-___-____ WORK___-___-____
MOTHER'S NAME_____ ADDRESS_____
EMPLOYED BY_____ PHONE ___-___-____ WORK___-___-____
ARE YOU ASSOCIATED WITH A DENTAL INSURANCE PLAN? □ yes □ no
NAME OF INSURANCE COMPANY _____ POLICY#_____
NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT _____
_____
ANY BROTHERS OR SISTERS? _____ LIST AGES_____
IS THIS YOUR CHILDS FIRST DENTAL EXPERIENCE? □ yes □ no
WHAT IS YOUR CHILD'S ATTITUDE TOWARDS THIS VISIT? _____
WHOM MAY WE THANK FOR REFFERING YOU TO OUR OFFICE?_____

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?
□ Kidney Disease □ Anemia
□ Diabetes □ Asthma
□ Rheumatic fever □ Heart trouble
□ Hepatitis □ Epilepsy/ convulsions
□ Liver disease □ Speech impediment
□ Tuberculosis □ Hearing problem
□ Other
Is child allergic to (please check):
□ Penicillin □ Codeine □ Novocaine □ Other
Is child taking any medications now? □ yes □ no
If so, what?_____
Does child have any allergies? □ yes □ no
Does child have emotional problems? □ yes □ no
Is child subject to prolonged bleeding? □ yes □ no

DENTAL HEALTH HISTORY

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: □ bottle nursing
□ thumb sucking □ mouth breathing
Has the child had teeth removed? □ yes □ no
Orthodontic treatment? □ yes □ no
Have a "sweet" tooth? □ yes □ no
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? □ yes □ no
Has anyone explained the importance of primary teeth? □ yes □ no

I, _____, verify the above and give my consent for treatment.

_____
Parent or Guardian's Signature

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.