

child's 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.

CHILD'S NAME _____ DATE _____ DATE OF BIRTH _____

SCHOOL _____ GRADE _____

RESIDENCE _____

CITY _____ STATE _____ ZIP _____

FATHER'S NAME _____

ADDRESS _____ HOME PHONE / _____ HOW LONG? _____

EMPLOYED BY _____ BUSINESS PHONE _____

MOTHER'S NAME _____

ADDRESS _____ HOME PHONE / _____ HOW LONG? _____

EMPLOYED BY _____ BUSINESS PHONE _____

ARE YOU ASSOCIATED WITH A DENTAL INSURANCE PLAN? _____ NAME OF INSURANCE COMPANY _____
_____ UNION (LOCAL #) _____ UNION HEAD _____ POLICY # _____

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

LAST NAME _____ FIRST NAME _____

DATE OF EXAM _____

MEDICAL HEALTH HISTORY

General health excellent good fair poor

Who is child's physician?
Address?

When did child have last complete physical examination?

Is child being treated for anything now?

- | | | |
|---|---|---|
| <input type="checkbox"/> Did child ever have
<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Liver disease
<input type="checkbox"/> Tuberculosis | <input type="checkbox"/> AIDS or HIV +
<input type="checkbox"/> Anemia
<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart trouble
<input type="checkbox"/> Epilepsy/convulsions
<input type="checkbox"/> Speech impediment
<input type="checkbox"/> Hearing problem | <input type="checkbox"/> Bone disorders
<input type="checkbox"/> Endocrine
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Broken bones
<input type="checkbox"/> High fever
<input type="checkbox"/> Other |
|---|---|---|

Is child allergic to
 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

1. How long since your last dental examination?

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

3. Does your child ever have dental pain? If so when?

4. Did child ever have a negative dental experience?
Discuss

5. Has the patient had any injuries to the face?
(Please Check)
 mouth teeth face

6. Has the patient ever sucked a thumb or fingers?
Until what age? _____

7. Does the patient have any speech problems?

8. Is the patient a mouth-breather?
While awake? _____ While asleep? _____

9. Has the child had teeth removed?

10. Has child had orthodontic treatment?

11. How often does your child brush?
Floss?

12. Has child received any fluoride treatment?
 pill/vitamins topical water

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