

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 their life.

DATE _____

CHILD'S NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ SCHOOL _____ GRADE _____

RESIDENCE _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____

FATHER'S NAME _____ HOME PHONE _____

ADDRESS _____ HOW LONG? _____

EMPLOYED BY _____ BUSINESS PHONE _____ CELL PHONE _____

MOTHER'S NAME _____ HOME PHONE _____

ADDRESS _____ HOW LONG? _____

EMPLOYED BY _____ BUSINESS PHONE _____ CELL PHONE _____

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

_____ POLICY NUMBER _____

_____ UNION (LOCAL #) _____ UNION HEAD _____

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT _____

ANY BROTHERS OR SISTERS? _____ LIST FIRST NAMES & 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

Child's General Health (please check):

- Excellent
- Good
- Fair
- Poor

Who is child's physician?

Physician's address

When did child have last complete physical examination?

Is child being treated for anything now?

Does child have or ever had:

- Kidney Disease
- Diabetes
- Rheumatic Fever
- Hepatitis
- Liver Disease
- Tuberculosis
- Anemia
- AIDS or HIV +
- Asthma
- Heart Trouble
- Epilepsy/Convulsions
- Speech Impediment
- Hearing Problem
- High Cholesterol
- Other _____

Is child allergic to (Please check):

- Penicillin
 - Novocaine
 - Codeine
 - Other
 - Latex
- Is child allergic to any other drugs?
If so, what? _____

Is child taking any medications now?

(Please specify)

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 Name _____

Parent or Guardian's Signature _____

DENTAL HEALTH HISTORY - CHILD

Date of your child's last dental exam

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

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

Did your child ever have a negative dental experience? Discuss

Mouth habits:

- Thumb sucking
- Mouth breathing
- Bottle nursing

Has your child had teeth removed?

Has child had orthodontic treatment?

Does your child have a "sweet" tooth?

How often does your child brush?
Floss?

Has your child received any fluoride treatment?

- pill / vitamins
- topical
- water

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

Has anyone explained the importance of primary teeth?