Child Registration and Health Record

Date_____ Child's Name_____ Date of Birth _____

Sex___ Child's Hobbies/Interests_____

Names of Parents/Legal Guardians_____

Address of Parents/Legal Guardians_____

Home Phone_____ Work Phone_____ Cell_____

Emergency Contact and Phone #_____

Dental Insurance Carrier (if applicable)_____

Medical Health

Name of Physician_____ Date last seen by Physician_____

List any medications taken recently by child and reason for taking

_____

_____

Please mark all that apply. Has child ever been treated for:

Abnormal Blood Pressure…….___ Asthma…….___

Diabetes…….___ Epilepsy/Seizures……___

Congenital Heart Defects…….___ Cancer…….___

Other physical conditions we should be aware of:_____

_____

Allergies to: Penicillin__ Codeine__ Local Anesthetics___ Other_____

Has child ever been hospitalized?___ If so, for what_____

Dental Health

Reason for visit:_____ Date of last dental visit_____

Has child had any problems with prior dental experiences?__ If so, please explain_____

_____

Is child currently experiencing pain associated with teeth?_____

Please add anything else you feel is important for us to know:_____

_____

_____

_____

Thank you for giving us the opportunity to provide your dental care.