



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.