

# CHILD'S REGISTRATION AND HISTORY

Date \_\_\_\_\_

Male \_\_\_\_\_

Female \_\_\_\_\_

Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ School \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City State Zip

Father's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Phone \_\_\_\_\_

Address (if different) \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Name/City Position Cell Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Phone \_\_\_\_\_

Address (if different) \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_

Name/City Position Cell phone \_\_\_\_\_

Parents: Are you \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_ Single

Other family members that we see: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Nearest Friend or Relative's Name, Address, Phone: \_\_\_\_\_

**EMAIL ADDRESS:** \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Subscriber's Name (primary insurance) Birthdate SS#

Insurance Company Phone Employer Group #

Subscriber's Name (secondary insurance) Birthdate SS#

Insurance Company Phone Employer Group #

## DENTAL HISTORY

What is the reason for this visit? \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ For what service? \_\_\_\_\_

Date of last cleaning: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

Name of your child's former dentist: \_\_\_\_\_ Phone # \_\_\_\_\_

What is your child's attitude toward dentistry? \_\_\_\_\_

Has there been any difficulty with treatment in the past? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Have there been any injuries to head-mouth-teeth? \_\_\_\_\_

Any mouth habits (thumb-pacifier-bottle-speech-etc)? \_\_\_\_\_

Family history of missing or extra teeth? \_\_\_\_\_

Does your child brush daily? \_\_\_\_\_ How many times? \_\_\_\_\_

Do you assist your child with tooth brushing: \_\_\_\_\_ How often? \_\_\_\_\_

Is dental floss used? \_\_\_\_\_ How often? \_\_\_\_\_

Do you have well water? \_\_\_\_\_ Has it been tested for fluoride? \_\_\_\_\_

Do you filter your drinking water? \_\_\_\_\_ Has your child had fluoride? \_\_\_\_\_ Drops/tablets? \_\_\_\_\_

If there is a need: May we use local anesthetic? \_\_\_\_\_ Nitrous oxide gas? \_\_\_\_\_

## MEDICAL HISTORY

Your Child's General Health (please check):  Excellent  Good  Fair  Poor

Is your child under the care of a physician at the present time? \_\_\_\_\_  
If yes, what is the condition being treated? \_\_\_\_\_

Please list ALL medication NOW being taken: \_\_\_\_\_

Name of child's physician: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Does your child have any history of rheumatic fever, heart murmur, or other heart defect? \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

Are childhood vaccinations up to date? \_\_\_\_\_ Date of last tetanus: \_\_\_\_\_

Does your child have any excessive bleeding when cut? \_\_\_\_\_  
Has your child ever been hospitalized or had surgery? \_\_\_\_\_  
If yes, when and for what reason: \_\_\_\_\_

Does your child have any communication, emotional, genetic, mental or physical problems? \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

Is your child Adopted? \_\_\_\_\_ If yes, what age? \_\_\_\_\_ Country \_\_\_\_\_

Check any of the following which your child has had or presently has:

<input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Chronic Ear Infections	<input type="checkbox"/> Malignancies or tumors
<input type="checkbox"/> AIDS / ARAC / HIV	<input type="checkbox"/> Chronic Swollen Glands	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Oral Lesions
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy / Convulsions	<input type="checkbox"/> Premature Birth
<input type="checkbox"/> Aspergers	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gastric Reflux	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Autism / Spectrum	<input type="checkbox"/> Heals slowly	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Ulcers or Stomach Problems
<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Unintentional Weight Loss
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Chronic Cold Sores	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Other _____

Are there any medical problems, conditions, or diseases not mentioned above that we should be aware of:  
\_\_\_\_\_

Is your child allergic or have sensitivity to any of the following:

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Nitrous Oxide	<input type="checkbox"/> Latex Gloves
<input type="checkbox"/> Sulfa	<input type="checkbox"/> Codeine	<input type="checkbox"/> Local Anesthetic	Other _____
<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Iodine	<input type="checkbox"/> Dental Materials	Other _____

Child's Weight \_\_\_\_\_

Height \_\_\_\_\_

\*\*\* PLEASE NOTE THAT ANY CHANGES IN YOUR CHILD'S HEALTH STATUS SHOULD BE REPORTED TO OUR OFFICE AT THE EARLIEST POSSIBLE TIME \*\*\*

\*\*\*WE ASK THAT YOU REMAIN IN OUR OFFICE WHILE YOUR CHILD IS TREATED\*\*\*

### CONSENT FOR TREATMENT

I hereby authorize Dr. Maxwell, Dr. Rastogi and Associate Dentists and their staff to complete a dental examination and take any necessary radiographs (x-rays) for my child. I further give permission for the doctors or their staff permission to perform a cleaning and apply fluoride if indicated (unless these have been done in the last 6 months). Prior to any other dental treatment such as fillings or extractions, I will be informed in advance about the details of the recommended dental services for my child. I am aware that I can remain in the treatment room with my child if I wish to do so. I assume complete responsibility for payment of all services rendered.

\_\_\_\_\_  
Parent / Guardian's Signature

\_\_\_\_\_  
Date

04/12

We will take reasonable steps to provide free-of-charge language assistance services to people who speak languages we are likely to hear in our practice and who don't speak English well enough to talk to us about the dental care we are providing.