ARTHUR STREET DENTAL OFFICE

CHILD'S REGISTRATION AND HISTORY

Date _____

Child's Name_____ Nickname_____

Age_____ Date of Birth _____

School_____

Residence Address_____City_____ Postal Code _____

Mother's name _____

Phone _____ Business _____

Father's name _____

Phone _____ Business _____

Name of Dental Insurance Company _____

You were referred to us by_____

What is the Child's Favorite Sport/Hobby/Toy _____

DENTAL HISTORY

Date of Last Dental Visit _____

For What Service _____

Any Dental Problems_____

Any unhappy Dental Experiences ❑ Yes ❑ No

Any injuries to Head/Mouth/Teeth ❑ Yes ❑ No

Any Mouth Habits? ❑ Thumb sucking ❑ Nail Biting ❑ Mouth Breathing ❑ Pacifier

Unusual Speech habits _____

Does the child Brush Daily ❑ Yes ❑ No

Does Parent Assist Child ❑ Yes ❑ No

How often?_____

Is Dental Floss Used ❑ Yes ❑ No

Is fluoride taken in any form ❑ Yes ❑ No

Child's attitude towards dentistry _____

Would you like regular care ❑ Yes ❑ No

Orthodontic appliances worn now or past _____

HEALTH HISTORY

Child's Physician _____ Address _____

Date of last Medical Visit_____

Is Child seeing Physician Now? ❑ Yes ❑ No

Is Child taking any Medications or Drugs? ❑ Yes ❑ No

Does Child Bleed Excessively when cut? ❑ Yes ❑ No

Has Child ever been Hospitalized or had surgery? ❑ Yes ❑ No

Any Allergies to Medications? ❑ Yes ❑ No