

CHILD'S REGISTRATION AND HISTORY

			Date	
Child's name	Nickname	Age	Birth date	
Residence address	City	State	Zip	
School	Address		Grade	
Father's name		Mother's name		
Father employed by	How long	Home phone	Bus. phone	
Mother employed by	How long	Home phone	Bus. phone	
Person financially responsible (if other than parent)		Relationship to child		
Address	City	State	Zip	Phone
Father's Social Security number		Driver license no.		State
Mother's Social Security number		Driver license no.		State
Father's birth date		Mother's birth date		
Credit card name	No.	Expiration date		
When dental insurance coverage name of carrier				
Secondary insurance coverage, if any				
Whom may we thank for referring you				

What is child's favorite: sport toy hobby person fictional character

DENTAL HISTORY

	Yes	No	Yes	No
Date of last visit to a dentist _____			Does your child brush teeth daily _____	<input type="checkbox"/> <input type="checkbox"/>
For what service _____			Do you assist child with tooth brushing _____	<input type="checkbox"/> <input type="checkbox"/>
_____			How often _____	
Has child complained about dental problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Is dental floss used _____	<input type="checkbox"/> <input type="checkbox"/>
_____			How often _____	
Any unhappy dental experiences _____	<input type="checkbox"/>	<input type="checkbox"/>	Are disclosing tablets used _____	<input type="checkbox"/> <input type="checkbox"/>
_____			Is fluoride taken in any form _____	<input type="checkbox"/> <input type="checkbox"/>
Any injuries to mouth - teeth - head _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	
_____			Do you desire complete dental service for the child _____	<input type="checkbox"/> <input type="checkbox"/>
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	
_____			Child's attitude to dentistry _____	
Any unusual speech habits _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	
_____			Summary (for doctor's use) _____	
Any lost teeth _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	
_____			_____	
Have missing teeth been replaced _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	
_____			_____	
Orthodontic appliances worn now or ever been _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	