child's registration & health history questionnaire

WELCOME TO AMERICAN DENTAL CENTER

You, as a parent, want to help your child to good oral health. Modern science is making many important contributions to better oral health, but the individual must still take the major responsibility for the care of his/her own mouth. You can teach your child to do so. With proper personal and professional care, your child may keep his/her teeth all his life.

DATE _____

CHILD'S NAME _____ DATE OF BIRTH _____ / _____ / _____ (Month / Day / Year)

SCHOOL _____ GRADE _____

RESIDENCE _____

CITY _____ STATE _____ ZIP _____

FATHER'S NAME _____

ADDRESS _____ HOW LONG? _____

EMPLOYED BY _____ HOME PHONE / BUS. PHONE _____

MOTHER'S NAME _____

ADDRESS _____ HOW LONG? _____

EMPLOYED BY _____ HOME PHONE / BUS. PHONE _____

ARE YOU ASSOCIATED WITH A DENTAL INSURANCE PLAN? _____ NAME OF INSURANCE COMPANY _____

_____ POLICY NUMBER _____

_____ UNION (LOCAL #) _____ UNION HEAD _____

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT _____

_____

ANY BROTHERS OR SISTERS? _____ LIST AGES _____

IS THIS YOUR CHILD'S FIRST DENTAL EXPERIENCE? _____

WHAT IS THE CHILD'S ATTITUDE TOWARDS THIS VISIT? _____

_____

_____

_____

COMMENTS: _____

_____

_____

_____

HOW DID YOU FIRST HEAR ABOUT AMERICAN DENTAL CENTER? _____

THANK YOU

LAST NAME _____ FIRST NAME _____ DATE OF EXAM _____

MEDICAL HEALTH HISTORY

General Health

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Who is child's physician?

Address?

When did child have last complete physical examination?

Is child being treated for anything now?

Did child ever have:

☐ Kidney Disease	☐ AIDS or HIV +	☐ Hearing Problem	☐ Other:
☐ Diabetes	☐ Anemia	☐ Bone Disorders	
☐ Rheumatic Fever	☐ Asthma	☐ Endocrine	_____
☐ Hepatitis	☐ Heart Trouble	☐ Arthritis	
☐ Liver Disease	☐ Epilepsy / Convulsions	☐ Broken Bones	_____
☐ Tuberculosis	☐ Speech Impediment	☐ High Fever	

	Yes	No
Is child allergic to: ☐ Penicillin ☐ Codeine ☐ Novocaine ☐ Other		
Is child taking any medications now? If so, what?		
Does child have any allergies?		
Is child subject to prolonged bleeding?		
Does child have any emotional problems?		

_____

Parent's Signature

_____

Parent's Social Security No.