

REGISTRATION AND HEALTH HISTORY

Name _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Spouse Name _____

Social Security number _____

Birthdate _____

Residence address _____

City _____

State _____

Zip _____

Home phone _____

Employed by _____

City _____

State _____

Zip _____

Business phone _____

Present position _____

How long held _____

Your driver license no. _____

State _____

Spouse employed by _____

City _____

State _____

Zip _____

Phone _____

Present position _____

How long held _____

Spouse driver license no. _____

State _____

Spouse's Social Security number _____

Spouse birthdate _____

Referred by _____

Address _____

Who will pay for this account? _____

Credit card name _____

No. _____

Expiration date _____

Name of your dental insurance company _____

Union local _____

Group no. _____

Policy no. _____

Name of your spouse's dental insurance company _____

Union local _____

Group no. _____

Policy no. _____

It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your written permission.

YOUR DENTAL HISTORY

Are you having any discomfort at this time _____ How long since you have been to a dentist _____ What was done then _____

Did you have X-Rays _____ How often did you visit a dentist before then _____ Have you lost any teeth _____ Why _____

Any complications with extractions _____

Have they ever been replaced by: (1) A Fixed Bridge _____

(2) Removable Partial _____ (3) Denture _____

How many of (1) (2) (3) _____

Are your teeth sensitive to heat _____ to cold _____ to sweets _____ to sour _____ Have you had your teeth straightened _____

When _____ How often do you brush your teeth _____ When _____

How _____

How long do you use a toothbrush before replacing it _____

Do you use dental floss _____ How often _____

Between-the-teeth stimulator _____ Water jet _____

Do you have bleeding gums _____ When _____

Do you eat between meals _____ Do you brush teeth after

snacks _____ Does food wedge between your teeth _____

Where _____ Do you grind or clench

your teeth _____ When _____

Have you ever had gum treatments _____ When _____

Do you feel you have bad breath at times _____

Unpleasant taste in mouth _____ Any pain in or around

your ears _____ Do you hear popping, clicking or snapping

noises when you chew _____ Do you have any nasal

obstruction _____ Are you aware of any swelling or lump

in your mouth _____

CHILD'S REGISTRATION AND HISTORY

			Date		
Child's name	Nickname	Age	Birthdate		
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 birthdate		Mother's birthdate			
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, pacifer, 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"/>	_____	

HEALTH HISTORY

Child's physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	Yes	No		Yes	No
Is child under care of physician now _____	<input type="checkbox"/>	<input type="checkbox"/>	Does child have good physical coordination _____	<input type="checkbox"/>	<input type="checkbox"/>
Is child receiving any medication or drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	Are there any emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Is there any excessive bleeding when cut _____	<input type="checkbox"/>	<input type="checkbox"/>	Summary (for doctor's use) _____		
Has child ever been hospitalized _____	<input type="checkbox"/>	<input type="checkbox"/>			
Has child ever had surgery _____	<input type="checkbox"/>	<input type="checkbox"/>			
Is there any allergy to penicillin or other drugs _____	<input type="checkbox"/>	<input type="checkbox"/>			
Are there other allergies: food - pollen - animals - dust - other _____	<input type="checkbox"/>	<input type="checkbox"/>			

Has child any history of or difficulty with any of the following:

- | | | | | |
|---|--|---------------------------------------|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic sinus | <input type="checkbox"/> Hearing | <input type="checkbox"/> Mastoid | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Rheumatic fever | |

Summary: (for doctor's use)

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

May we request release of your child's medical records for our reference _____ **Yes No**

This information was discussed with and given by _____

Relation to child _____