

# 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		
Cell Phone Number				
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"/>	_____		

