



Patient Registration: Dental and Medical Health History

Please complete this registration form. If you have any questions, please ask.

Patient's Name _____ Date of Birth _____ Today's Date _____
First name Last name Month/Day/Year Month/Day/Year

Dental History

- Is this your child's first dental visit? Yes No _____
Previous Dentist's Name _____
- Has your child ever had problems receiving dental care? Yes No _____
Explain Problem(s) _____
- Are you aware of any problems with your child's teeth? Yes No _____
Explain Problem(s) _____
- Who brushes the child's teeth at home? _____
Who Brushes? _____ How Often? _____
- Is the patient receiving fluoride in any form? Yes No _____
Type of Treatment _____
- Is there a history of trauma to the mouth/head/teeth? Yes No _____
Explain Problem(s) _____
- Does your child suck his/her thumb/fingers/pacifier? Yes No _____
Explain Problem(s) _____
- At what age did your child stop bottle feeding? _____ Breast feeding? _____

Medical History

Physician's/Clinic Name _____ Phone (_____) _____

Address _____
Street City State Zip

- If necessary, may we consult with this physician? Yes No _____
Special Instructions _____
- Are your child's vaccinations up to date? Yes No _____
Explain Problem(s) _____
- Please describe any health conditions that are of present concern (*medications, pending surgeries, recent injuries, issues related to healthcare*)

- Is your child being treated by a physician or alternative medicine practitioner at this time? Yes No _____
Please Describe _____
- Is your child taking any medicines, herbal medicines, homeopathic and/or nutritional supplements at this time? Yes No _____
Please list Medications, Remedies and/or Supplements _____

Medications, Remedies and/or Supplements
- Has your child ever been admitted to a hospital? Yes No _____
Please Describe _____
- Has your child ever received general anesthesia/sedation? Yes No _____
Please Describe _____
- Is your child allergic to any medicines/substances/foods? Yes No _____
Please name allergy source _____
- Has your child ever had a blood transfusion? Yes No _____
Please Describe _____

Birth History

- Full term Yes No _____
Please Describe _____
- Low birth weight and/or other complications Yes No _____
Please Describe _____
- Neo-natal Illness Yes No _____
Please Describe _____

Patient's Name _____ Date of Birth _____ Today's Date _____
First name Last name Month/Day/Year Month/Day/Year

Medical History (continued)

Please review the following groups of questions. Indicate if there is a current health problem, or if there was a problem in the past for your child.

Blood, Heart and Liver Organ Systems

| | | |
|--------------------|--|-------|
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Sickle Cell Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Other | | _____ |

Eyes, Ears, Nose, Throat and Pulmonary System

| | | |
|------------------------|--|-------|
| Eye Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Hearing Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Frequent Ear Infection | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Mouth Breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Frequent Sore Throat | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Snoring at Night | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Cleft Lip/Palate | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Other | | _____ |

Kidney and Bladder

| | | |
|---------------------|--|-------|
| Renal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Frequent Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Other | | _____ |

Endocrine and Glands

| | | |
|------------------|--|-------|
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Other | | _____ |

Muscles and Nervous System

| | | |
|----------------------|--|-------|
| Cerebral Palsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Convulsions/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Spina Bifida | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Other | | _____ |

Bones

| | | |
|---------------------|--|-------|
| Orthopedic Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Rickets | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Scoliosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Other | | _____ |

Psychological and Emotional

| | | |
|----------------------|--|-------|
| Clinical Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| ADD/ADHD | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Autism | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Brain Injury | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Cognitive Impairment | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Behavioral Issues | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Other | | _____ |

Childhood Disease History

| | | |
|-------------|--|-------|
| Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Other | | _____ |

Adolescent Social Issues that can Affect Dental Health

| | | |
|---------------------|--|-------|
| Pierced Lips/Tongue | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Alcohol | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Eating Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Substance Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Oral Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Pregnancy | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Other | | _____ |

Consent to Treatment

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated for my child. I understand the use of anesthetic agents embodies a certain risk. I have had the opportunity to ask questions and understand the benefits/risks of the proposed treatment for my child.

Signature _____ Date: _____ Dentist signature _____
Parent/Guardian Relationship to Child