CHILD'S REGISTRATION AND PERSONAL HEALTH HISTORY

Welcome to DENTAL ASSOCIATES FOR KIDS ONLY. The information which you are providing is an important aid in making a thorough evaluation of your child's dental health. It also allows us to more adequately plan for your child's emotional and dental needs. Therefore, this important document becomes an integral part of our continuing evaluation of your child's growth and development in these formative years. Our thanks for your cooperation.

Child's Name:_____ M__ F__ Nickname:_____

Address:_____Phone:_____

Town:_____ Zip:_____

Age:_____ D.O.B:_____ Place of Birth:_____

RESPONSIBLE PARTY: (If other than parents, please state name and relationship to child) _____

Father:_____
(If different from child)
Address:_____

Town: _____ Zip:_____

Home Phone: _____ Cell:_____
E-Mail Address: _____

Employer: _____Occupation:_____
Work #: _____ SS #:_____

Mother:_____
(If different from child)
Address:_____

Town:_____ Zip:_____

Home Phone: _____ Cell:_____
E-Mail Address _____

Employer: _____Occupation:_____
Work #: _____ SS#: _____

DENTAL INSURANCE: _____

MEDICAL HISTORY:

Child's Physician or Pediatrician: _____ Phone #: _____

Has your child ever been hospitalized for any illness, surgery? Yes_____ No _____, (if yes, please explain)
_____
Is your child currently taking any prescription medications? _____
Is your child allergic to any food or medicine including antibiotics and local anesthetic solutions?
_____
Does your child have a history of any of the following disorders?

____Allergy	**____Diabetes**	**____Heart Disorder**	**____Rheumatic Fever**
____Anemia	**____Emotional Disorder**	**____Kidney Disorder**	**____Learning Disabilities**
____Asthma	**____Epilepsy**	**___ Liver Disorder**	**____ADD/ADHD**
____Autism	**____Eye Disorder**	**____Malignancy/Neoplasm**	**____Stomach Ailment**
____Blood	**____Hearing Disorder**	**____Nervous Disorder**	**____Eating Disorder**
____Bleeding Disorder			

If your child has a heart disorder/murmur, does he/she need to be pre-medicated?_____

Is there anything else that you feel we should know about your child ? _____
Is this your child's first visit to a dental office?_____ Has your child ever had an unpleasant experience in a dental office? _____

Reason for today's visit? _____
Does your child take a prescription fluoride supplement? Yes_____ No _____ Age started? _____

Who may we thank for referring you: _____
Name and age of your other children: _____

Because your child is a minor, it becomes necessary that signed permission is obtained from a parent/guardian before any/all necessary dental services can be rendered. Furthermore, the undersigned will be responsible for any fee incurred on the above child for dental treatment rendered.

Authorization is hereby granted as such: NAME:_____DATE:_____
signature