

CHILD'S REGISTRATION AND HISTORY

DATE _____

CHILD'S NAME _____ NICKNAME _____ AGE _____ DATE OF BIRTH _____

SCHOOL _____ GRADE _____ RESIDENCE ADDRESS _____

CITY _____ PROVINCE _____

FATHER'S NAME _____ MOTHER'S NAME _____

FATHER EMPLOYED BY _____ HOME PHONE _____ BUS PHONE _____

MOTHER EMPLOYED BY _____ HOME PHONE _____ BUS PHONE _____

PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN PARENT) _____ RELATIONSHIP TO CHILD _____

ADDRESS _____ CITY _____ PROV. _____ ONT. _____ PHONE _____

WHEN DENTAL INSURANCE COVERAGE NAME OF CARRIER _____

WHOM MAY WE THANK FOR REFERRING YOU _____

WHAT IS CHILD'S FAVORITE SPORT _____ FAVORITE TOY _____

FAVORITE HOBBY _____ FAVORITE PERSON _____ FAVORITE FICTION CHARACTER _____

DENTAL HISTORY

| | 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"/> |
| _____ YES NO | 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"/> | _____ |
| _____ | Child's attitude to dentistry _____ |
| Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____ <input type="checkbox"/> <input type="checkbox"/> | _____ |
| _____ | Do you desire complete dental service for the child _____ <input type="checkbox"/> <input type="checkbox"/> |
| Any unusual speech habits _____ <input type="checkbox"/> <input type="checkbox"/> | _____ |
| _____ | _____ |
| Any lost teeth _____ <input type="checkbox"/> <input type="checkbox"/> | Summary (for doctor's use) _____ |
| _____ | _____ |
| 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"/> Malignancies | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart | <input type="checkbox"/> Mastoid | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other |

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

Parent/Guardian signature _____

Relation to child _____