

## Children's Patient Registration and Medical History

Patient Information:

(last name)

(first name)

(preferred name)

Date of birth: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home phone: \_\_\_\_\_

Person responsible for this account:

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Home phone: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Social security #: \_\_\_\_\_ Social security #: \_\_\_\_\_

Medical History

Child's Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Has your child ever had any of the following? (check all that apply)

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Heart problems    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure                              | <input type="checkbox"/> Circulatory Problems            |
| <input type="checkbox"/> Nervous Problems  | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Artificial Heart Valves                         | <input type="checkbox"/> Artificial Joints               |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Blood Disease                                   | <input type="checkbox"/> Asthma                          |
| <input type="checkbox"/> Heart Murmur      | <input type="checkbox"/> Sleep Apnea/Snoring | <input type="checkbox"/> Mouth Breathing                                 | <input type="checkbox"/> Epilepsy/Convulsions            |
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Jaundice or Liver Disease                       | <input type="checkbox"/> Cancer                          |
| <input type="checkbox"/> Psychiatric Care  | <input type="checkbox"/> Chronic diarrhea    | <input type="checkbox"/> Allergies to Anesthetics                        | <input type="checkbox"/> Allergies to Medicines or Drugs |
| <input type="checkbox"/> General Allergies | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Arthritis                                       | <input type="checkbox"/> Tuberculosis                    |
| <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Special Diet        | <input type="checkbox"/> Swollen neck glands                             | <input type="checkbox"/> Rheumatic Fever                 |
| <input type="checkbox"/> Sinus Problems    | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Ulcer   | <input type="checkbox"/> Venereal Disease                |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> AIDS, HIV, or Other Immunosuppressive Disorders |  |

Any operations? Please list: \_\_\_\_\_

Any disabilities? Please list: \_\_\_\_\_

Drug allergies or adverse reactions to medications? Please list: \_\_\_\_\_

Adverse response to medial or dental treatment? \_\_\_\_\_

Is this child currently taking any medication or supplements? Please list: \_\_\_\_\_

Is this child currently under a physician's care? Please describe: \_\_\_\_\_

Does your child?

Brush teeth daily? Y\_\_ N\_\_ Floss daily? Y\_\_ N\_\_ Take fluoride supplements? Y\_\_ N\_\_ Bite fingernails? Y\_\_ N\_\_  
 Suck thumb/fingers? Y\_\_ N\_\_ Use a bottle or pacifier? Y\_\_ N\_\_ Suck or bite lips or cheek? Y\_\_ N\_\_

Is there anything else we should know about your child's medical history? \_\_\_\_\_

The above information is accurate and complete to the best of my knowledge and is only for use in my child's treatment, billing, and processing of insurance. I will not hold the dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_