Gentle Family Dentistry (please fill out the front only)

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)

___Heart problems	___High Blood Pressure	___Low Blood Pressure	___Circulatory Problems
___Nervous Problems	___Radiation Treatment	___Artificial Heart Valves	___Artificial Joints
___Diabetes	___Respiratory Disease	___Blood Disease	___Asthma
___Heart Murmur	___Sleep Apnea/Snoring	___Mouth Breathing	___Epilepsy/Convulsions
___Headaches	___Hepatitis	___Jaundice or Liver Disease	___Cancer
___Psychiatric Care	___Chronic diarrhea	___Allergies to Anesthetics	___Allergies to Medicines or Drugs
___General Allergies	___Chemical Dependency	___Arthritis	___Tuberculosis
___Kidney Disease	___Special Diet	___Swollen neck glands	___Rheumatic Fever
___Sinus Problems	___Stroke	___Ulcer	___Venereal Disease
___Abnormal Bleeding	___Hemophilia	___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: _____