

CHILD'S REGISTRATION AND HISTORY

			Date	
Child's name	Nickname	Age	Birth date	
Residence address	City	State	Zip	
School	Address		Grade	
Father's name	Mother's name			
Father employed by	How long	Home phone	Bus. phone	
Mother employed by	How long	Home phone	Bus. phone	
Person financially responsible (if other than parent)		Relationship to child		
Address	City	State	Zip	Phone
Father's Social Security number	Driver license no.		State	
Mother's Social Security number	Driver license no.		State	
Father's birth date	Mother's birth date			
Credit card name	No.	Expiration date		
When dental insurance coverage name of carrier				
Secondary insurance coverage, if any				
Whom may we thank for referring you				
What is child's favorite: sport toy hobby person fictional character				

DENTAL HISTORY

	Yes	No		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"/>
			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"/>			
			Do you desire complete dental service for the child	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.	<input type="checkbox"/>	<input type="checkbox"/>			
			Child's attitude to dentistry		
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"/>			