Mt. View Family Dentistry
3055 NC 127 S, Hickory, NC 28602
828-294-1448

CHILD REGISTRATION AND HEALTH HISTORY

____/______/_____
Date

First Name ____ **(MI)** ____ **Last Name** ____ **Nickname** ____ **Birth Date** ____/______/_____ **Age** ____

Address ____ **City** ____ **State** ____ **Zip Code** ____

School ____ **Address** ____ **Grade** ____

Mother's Details ☐ **Primary Contact**

Name ____ **Home Phone** ____ **Cell Phone** ____

Employment ____ **Work Phone** ____

Social Security No. ____ **Driver's License No./ State** ____ **Birth Date** ____/______/________

Father's Details ☐ **Primary Contact**

Name ____ **Home Phone** ____ **Cell Phone** ____

Employment ____ **Work Phone** ____

Social Security No. ____ **Driver's License No./ State** ____ **Birth Date** ____/______/________

Person Financially Responsible (if other than parent) ____ **Relationship to Child** ____

Dental Insurance Carrier (if any) ____ **Whom may we thank for referring you** ____

DENTAL HISTORY

Date of last visit to dentist______/______/______ **For what service**____________________

1. Has child complained about dental problems ☐ **Yes** ☐ **No** ____________________
2. Any unhappy dental experiences ☐ **Yes** ☐ **No** ____________________
3. Any injuries to mouth-teeth-head ☐ **Yes** ☐ **No** ____________________
4. Any mouth habits (circle any that apply): thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier, other____________________
5. Any unusual speech habits ☐ **Yes** ☐ **No** ____________________
6. Any lost teeth ☐ **Yes** ☐ **No**
7. Have missing teeth been replaced ☐ **Yes** ☐ **No**
8. Orthodontic appliances ever been worn ☐ **Yes** ☐ **No**
9. Does child brush daily ☐ **Yes** ☐ **No**
10. Use floss ☐ **Yes** ☐ **No** **Frequency** __________
11. Use disclosing tablets ☐ **Yes** ☐ **No**
12. Use fluoride ☐ **Yes** ☐ **No** **In what form**______________ **Frequency** __________
13. Child's attitude to dentistry____________________

Mt. View Family Dentistry
3055 NC 127 S, Hickory, NC 28602
828-294-1448

HEALTH HISTORY

Child's physician____________________________ _____________________________________ __________________
Address **Phone No.**

Date of last physical exam _____/_____/_____ **Results**____

Is child currently under a physician's care ☐ **Yes** ☐ **No** **Reason**____

Is child receiving medication or drugs ☐ **Yes** ☐ **No** **List, if any** ____

Is there any excessive bleeding when cut ☐ **Yes** ☐ **No**

Has child ever been hospitalized ☐ **Yes** ☐ **No** **Reason**____

List any surgery child has ever had ____

Any allergy to penicillin or other drugs (specify)____

Any other allergies (food-pollen-animals-dust-other)____

Does child have good physical coordination ☐ **Yes** ☐ **No (specify)**____

Does child have any emotional problems ☐ **Yes** ☐ **No (specify)**____

Does child have any history of or difficulty with any of the following:

☐ **Anemia**	☐ **Chronic sinus**	☐ **Hearing**	☐ **Mastoid**	☐ **Rheumatic Fever**
☐ **Asthma**	☐ **Convulsions**	☐ **Heart**	☐ **Measles**	☐ **Thyroid**
☐ **Bladder**	☐ **Diabetes**	☐ **Kidney**	☐ **Mononucleosis**	☐ **Tuberculosis**
☐ **Cerebral Palsy**	☐ **Epilepsy**	☐ **Liver**	☐ **Malignancies**	☐ **Venereal Disease**
☐ **Chicken Pox**	☐ **Fainting**	☐ **Mumps**	☐ **Other** __________________________________	

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that has not been previously discussed

____
____
____
____
____

May we request release of your child's medical records for our reference ☐ **Yes** ☐ **No**

____ _______/_______/_______

Mt. View Family Dentistry
3055 NC 127 S, Hickory, NC 28602
828-294-1448

Parent/Guardian Signature **Date**