

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

Parent/Guardian Signature

_____/_____/_____
Date_