CHILD'S REGISTRATION AND HISTORY

DATE ______________

CHILD'S NAME ______________ NICKNAME ______________ AGE ______ DATE OF BIRTH ______________

SCHOOL ______________ GRADE ______ RESIDENCE ADDRESS ______________

CITY ______________ STATE ______________ ZIP ______________

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 ______________

PARENT'S SOCIAL SECURITY NUMBER ______________ DRIVER LICENSE NO. ______________ STATE ______________

CREDIT CARD NAME ______________ NO. ______________ EXPIRATION DATE ______________

WHEN DENTAL INSURANCE COVERAGE NAME OF CARRIER ______________

WHOM MAY WE THANK FOR REFERRING YOU ______________

WHAT IS CHILD'S FAVORITE SPORT ______________ FAVORITE TOY ______________

FAVORITE HOBBY ______________ FAVORITE PERSON ______________ FAVORITE FICTION CHARACTER ______________

DENTAL HISTORY

Date of last visit to a dentist ______________

For what service ______________

____

	YES	NO
Has child complained about dental problems ______________	☐	☐
Any unhappy dental experiences ______________	☐	☐
Any injuries to mouth - teeth - head ______________	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. ______________	☐	☐
Any unusual speech habits ______________	☐	☐
Any lost teeth ______________	☐	☐
Have missing teeth been replaced ______________	☐	☐
Orthodontic appliances worn now or ever been ______________	☐	☐

	YES	NO
Does your child brush teeth daily ______________	☐	☐
Do you assist child with tooth brushing ______________	☐	☐
How often ______________		
Is dental floss used ______________	☐	☐
How often ______________		
Are disclosing tablets used ______________	☐	☐
Is fluoride taken in any form ______________	☐	☐
Child's attitude to dentistry ______________		
Do you desire complete dental service for the child ______________	☐	☐

Summary (for doctor's use) ______________

Form 1022 ● 1981, SYCOM, Madison, WI Printed in U.S.A.

HEALTH HISTORY

Child's Physician ______________________ Address ______________________ Phone __________

Date of last physical examination ______________________ Results ______________________

	YES	NO
Is child under care of physician now ______________________	☐	☐
Is child receiving any medication or drugs ______________________	☐	☐
Is there any excessive bleeding when cut ______________________	☐	☐
Has child ever been hospitalized ______________________	☐	☐
Has child ever had surgery ______________________	☐	☐
Is there any allergy to penicillin or other drugs ______________________	☐	☐
Are there other allergies: food - pollen - animals - dust - other	☐	☐

	YES	NO
Does child have good physical coordination ______________________	☐	☐
Are there any emotional problems ______________________	☐	☐

Summary (for doctor's use) ______________________

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

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

SUMMARY: (for doctor's use)

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

May we request release of your child's medical records for our reference ______________________ YES ☐ NO ☐

This information was discussed with and given by ______________________

Relation to Child ______________________