

# KIDS FIRST

## PEDIATRIC DENTISTRY & ORTHODONTICS

### REGISTRATION AND HISTORY



DATE \_\_\_\_\_

PATIENT'S FULL NAME \_\_\_\_\_ M/F \_\_\_\_\_ NICK NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

RESIDENCE ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

BROTHER'S/SISTER'S NAMES AND AGES \_\_\_\_\_ FAVORITE HOBBY/TOY \_\_\_\_\_ FAVORITE PERSON \_\_\_\_\_ PRESENT WEIGHT \_\_\_\_\_

SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_ PET \_\_\_\_\_

### PARENT/GUARDIAN ACCOUNT INFORMATION

NAME: _____	NAME: _____
ADDRESS: _____	ADDRESS: _____
PHONE (HOME): _____	PHONE (HOME): _____
(CELL): _____ (WORK): _____	(CELL): _____ (WORK): _____
E-MAIL: _____	E-MAIL: _____
EMPLOYER/DIVISION: _____	EMPLOYER/DIVISION: _____
ADDRESS: _____	ADDRESS: _____
DENTAL INS. CO.: _____	DENTAL INS. CO.: _____
INS. ADDRESS: _____	INS. ADDRESS: _____
MEMBERSHIP/POLICY#: _____	MEMBERSHIP/POLICY#: _____
SOCIAL SECURITY#: _____	SOCIAL SECURITY#: _____
DATE OF BIRTH: _____	DATE OF BIRTH: _____
PERSON FINANCIALLY RESPONSIBLE: _____	RELATIONSHIP: _____

**PLEASE TELL US HOW YOU HEARD OF OUR PRACTICE**

(We would like to thank them)

### DENTAL HISTORY

<p>Reason for visit <input type="checkbox"/> Routine Care <input type="checkbox"/> Orthodontic Care</p> <p>Specific Concerns: _____</p> <p>Is this the first dental visit? (Yes or No) _____</p> <p>If No, previous dentist's name: _____</p> <p>Date of last visit: _____</p>	<table border="0" style="width: 100%;"> <thead> <tr> <th></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td>Have missing teeth been replaced _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Orthodontic appliances worn now or ever been _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Parents ever wear braces _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Does your child brush daily _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Does your child use toothpaste _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Do you assist child with tooth brushing _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>How often _____</td> <td></td> <td></td> </tr> <tr> <td>Is dental floss used _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>How often _____</td> <td></td> <td></td> </tr> <tr> <td>Family history of gum disease _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Parents' history of dental decay _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Parents' history of dental decay _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Do you have well or city H2O _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Does your child take fluoride supplements _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Child's attitude to dentistry _____</td> <td></td> <td></td> </tr> <tr> <td>Parents' attitude toward dentistry _____</td> <td></td> <td></td> </tr> </tbody> </table>		YES	NO	Have missing teeth been replaced _____	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic appliances worn now or ever been _____	<input type="checkbox"/>	<input type="checkbox"/>	Parents ever wear braces _____	<input type="checkbox"/>	<input type="checkbox"/>	Does your child brush daily _____	<input type="checkbox"/>	<input type="checkbox"/>	Does your child use toothpaste _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you assist child with tooth brushing _____	<input type="checkbox"/>	<input type="checkbox"/>	How often _____			Is dental floss used _____	<input type="checkbox"/>	<input type="checkbox"/>	How often _____			Family history of gum disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Parents' history of dental decay _____	<input type="checkbox"/>	<input type="checkbox"/>	Parents' history of dental decay _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you have well or city H2O _____	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take fluoride supplements _____	<input type="checkbox"/>	<input type="checkbox"/>	Child's attitude to dentistry _____			Parents' attitude toward dentistry _____		
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# MEDICAL AND HEALTH HISTORY

Child's Physician \_\_\_\_\_ Address \_\_\_\_\_ Tel. \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_

- |  |   |
|--|---|
| <p>1. Is child under care of physician now? _____ <input type="checkbox"/> <input type="checkbox"/><br/>Name of Dr. _____</p> <p>2. Is child receiving any medication or drugs? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>3. Is child taking any herbal supplements? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>4. Is there any excessive bleeding when cut? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>5. Any bleeding disorders in the family? _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Has child ever been hospitalized? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>7. Has child ever had surgery? _____ <input type="checkbox"/> <input type="checkbox"/><br/>Reason: _____</p> <p>8. Is there any allergy to penicillin or other drugs? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> | <p>9. Are there other allergies? latex-food-pollen-animals- dust-other? _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>10. Does child have good physical coordination? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>11. Are there any physical problems? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>12. Any learning difficulties? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>13. Does child get upset easily? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>14. Any problems at birth/before birth? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>15. Immunizations current? _____ <input type="checkbox"/> <input type="checkbox"/></p> |
|--|---|

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

- |   |  |   |                                       |  |
|---|--|---|---------------------------------------|--|
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> Chronic Sinus       | <input type="checkbox"/> HIV                  | <input type="checkbox"/> Kidney       | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Convulsions         | <input type="checkbox"/> Hearing              | <input type="checkbox"/> Liver        | <input type="checkbox"/> Strep Throat    |
| <input type="checkbox"/> Bladder        | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart / Heart Murmur | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Thyroid         |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Mastoid      | <input type="checkbox"/> Transfusions    |
| <input type="checkbox"/> Chicken pox    | <input type="checkbox"/> Fainting            | <input type="checkbox"/> High Fever           | <input type="checkbox"/> Measles      | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Headaches      | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Mononucleosis        | <input type="checkbox"/> Mumps        | <input type="checkbox"/> Other           |

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of: \_\_\_\_\_

YES NO

May we request release of your child's medical records for our reference \_\_\_\_\_

**PERMIT FOR TREATMENT UPON A MINOR**

The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my child's medical status. I, being the parent or guardian of the above minor patient, do request and authorize the performance of dental services for this patient, and the performance of whatever procedures or techniques the Doctor may deem necessary during performance of any operation or treatment.

I authorize the administration of anesthetics or analgesics which may be deemed advisable by the Doctor.

Furthermore, I understand as the parent or guardian who accompanies the child I will be responsible for all financial obligations incurred on this child for dental treatment.

I give my permission to use these records for consultations and educational purposes.

This information was provided by and discussed with: \_\_\_\_\_  
(signature and relationship to patient)

**SUMMARY: (for doctor's use)**