CHILD'S REGISTRATION AND HISTORY

DATE _____

CHILD'S NAME _____ NICKNAME _____ AGE _____ DATE OF BIRTH _____

SCHOOL _____ GRADE _____ RESIDENCE ADDRESS _____

CITY _____ PROVINCE _____

FATHER'S NAME _____ MOTHER'S NAME _____

FATHER EMPLOYED BY _____ HOME PHONE _____ BUS PHONE _____

MOTHER EMPLOYED BY _____ HOME PHONE _____ BUS PHONE _____

PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN PARENT) _____ RELATIONSHIP TO CHILD _____

ADDRESS _____ CITY _____ PROV. _____ ONT. _____ PHONE _____

WHEN DENTAL INSURANCE COVERAGE NAME OF CARRIER _____

WHOM MAY WE THANK FOR REFERRING YOU _____

WHAT IS CHILD'S FAVOURITE SPORT _____ FAVOURITE TOY _____

FAVOURITE HOBBY _____ FAVOURITE PERSON _____ FAVOURITE FICTION CHARACTER _____

DENTAL HISTORY

Date of last visit to a dentist _____

For what service _____

_____ YES ☐ NO ☐

Has child complained about dental problems _____ YES ☐ NO ☐

_____

Any unhappy dental experiences _____ YES ☐ NO ☐

_____

Any injuries to mouth - teeth - head _____ YES ☐ NO ☐

_____

Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____ YES ☐ NO ☐

_____

Any unusual speech habits _____ YES ☐ NO ☐

_____

Any lost teeth _____ YES ☐ NO ☐

_____

Have missing teeth been replaced _____ YES ☐ NO ☐

_____

Orthodontic appliances worn now or ever been _____ YES ☐ NO ☐

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 dentist service for the child _____ ☐ ☐

_____

_____

Summary (for doctor's use) _____

_____

_____

_____

_____

HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO
Is the 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	___ Malignancies	___ Rheumatic fever
___ Asthma	___ Convulsions	___ Heart	___ Mastoid	___ Thyroid
___ Bladder	___ Diabetes		___ Measles	___ Tuberculosis
___ Cerebral Palsy	___ Epilepsy	___ Kidney	___ Mononucleosis	___ Tonsilitis
___ Chicken Pox	___ Fainting	___ Liver	___ Mumps	___ Other

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 record for our reference _____ Yes ☐ No ☐

Parent/Guardian signature _____

Relation to child _____