

CHILD'S REGISTRATION AND HISTORY

PLEASE FILL OUT THIS FORM COMPLETELY. THE BETTER WE COMMUNICATE,
THE BETTER WE CAN CARE FOR YOU.

Child's Name _____ Age _____ Date of Birth _____ Date _____
Nickname _____ School _____ Grade _____
Residence Address _____ City _____ State _____ Zip _____

Father's Name _____ Father's Social Security Number _____
Father Employed By _____ Work Phone _____ Home Phone _____

Mother's Name _____ Mother's Social Security Number _____
Mother Employed By _____ Work Phone _____ Home Phone _____

Guardian's Name _____ Bus. Phone _____ Home Phone _____
Address _____ City _____ State _____ Zip _____

Person Responsible For This Account _____ Relation to Child _____
Dental Insurance Company _____ Date of Birth _____

Person Responsible for Making Appointments _____
Work Phone _____ Home Phone _____ Cell Phone _____

Who May We Thank for Referring You? _____

DENTAL HISTORY

Date of Last Visit to Dentist _____
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 – thumb sucking,
nail biting, nursing bottle habits, pacifier,
clenching, grinding teeth, etc. Yes No

Any Unusual Speech Habits Yes No
Orthodontic Appliances Worn Now Yes No
Child's Attitude Toward Dentistry _____

Does Your Child Brush Daily? Yes No

Do You Assist Your Child W/Tooth
Brushing? Yes No
How Often _____

Is Dental Floss Used? Yes No
How Often _____

Summary (For Doctor's Use) _____

HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____
 Date of last physical examination _____ Results _____

Is child under care of physician now _____	Yes	No	Does child have good physical coordination	Yes	No
Is child receiving any medication or drugs _____	Yes	No	Are there any emotional problems _____	Yes	No
Is there any excessive bleeding when cut _____	Yes	No	Summary (for doctor's use) _____		
Has child ever had surgery _____	Yes	No	_____		
Is there any allergy to penicillin or other Drug _____	Yes	No	_____		
Are there other allergies: food-pollen-animals-dust-other _____	Yes	No	_____		
_____			_____		
_____			_____		

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

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hearing | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV+ | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis(TB) |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver/Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chronic Sinus | <input type="checkbox"/> Handicap/Disability | | | |

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.

I understand that the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's medical status. I give permission to perform the necessary dental services my child may need. I authorize my insurance benefits to be paid directly to Richard S Boyes D.M.D. I understand that I am financially responsible for ALL services, to include interest and rebilling charges. I authorize Dr. Boyes to release any information I have either read or received a copy of this office privacy policy (HIPAA)

 Signature of Parent or Guardian Date

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 _____

SUMMARY: (For Doctor)
