river city
pediatric dentistry

CHILD'S REGISTRATION AND PERSONAL HEALTH HISTORY

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ABOUT YOUR CHILD

Child's Name_____ Preferred Name_____ Birthdate____/____/____ Male___ Female ____

Place of Birth_____ Child's Favorite Toy _____

Child's Pets _____ Child's Hobbies _____

Names and birthdates of siblings _____

What school does your child attend?_____

Does your child have any social difficulties? _____

Does your child have any scholastic difficulties?_____

Please describe your child's temperament _____

How did you hear about our office?_____ If you were referred to our office, by whom? _____

Address of referrer? *(we would like to thank them)*_____

GENERAL INFORMATION

- Parent_____ Social Security Number_____

  Address_____ City_____ St_____ Zip _____

  Phone_____ Additional Phone_____ E-mail_____

- Parent_____ Social Security Number_____

  Address_____ City_____ St_____ Zip _____

  Phone_____ Additional Phone_____ E-mail_____

- Custodial Parent_____ Social Security Number_____

  Address_____ City_____ St_____ Zip _____

  Phone_____ Additional Phone_____ E-mail_____

Dental Insurance Yes ❑ No ❑

Insured's Name:_____ Social Security Number_____

DENTAL HISTORY

Purpose of visit? _____

Who is your family dentist?_____ Has your child ever visited the dentist? _____

Name of previous dentist?_____ Date of last visit? _____

The reason for seeing the previous dentist? _____

How was your child's experience at the previous dentist? _____

Does your child have any oral habits? (finger sucking, grinding teeth, etc.) _____

Do you think your child's bite is good or bad?_____

At what age did your child discontinue bottle feeding or nursing?_____ Does your child receive any fluoride at home? _____

Has there been any injury to the teeth or mouth?_____ How would you rate your child's oral hygiene? _____

Is there any family history of unusual dental problems?_____ Has your child ever had a toothache? _____

Does your family use city water or well water?_____ Is your child in any pain now? _____

MEDICAL ALERTS

Allergic to

- ☐Y ☐N No known allergies
- ☐Y ☐N Aspirin
- ☐Y ☐N Ibuprofen/Mortin
- ☐Y ☐N Tylenol
- ☐Y ☐N Codeine
- ☐Y ☐N Erythromycin
- ☐Y ☐N Latex
- ☐Y ☐N Local Anesthetics
- ☐Y ☐N Metals
- ☐Y ☐N Epinephrine
- ☐Y ☐N Environmental allergies
- ☐Y ☐N Food or Fruit
- ☐Y ☐N Milk
- ☐Y ☐N Peanut allergy
- ☐Y ☐N Omnicef
- ☐Y ☐N Penicillin
- ☐Y ☐N Amoxicillin
- ☐Y ☐N Augmentin
- ☐Y ☐N Sulfa Drugs
- ☐Y ☐N Other allergies-see below

Check if applicable

- ☐Y ☐N No known concerns / issues
- ☐Y ☐N Antibiotic Prophylaxis (needs antibiotics before going to dentist)
- ☐Y ☐N ADHD
- ☐Y ☐N AIDS / HIV infection
- ☐Y ☐N Anemia / Leukema
- ☐Y ☐N Asthma / Hay Fever
- ☐Y ☐N Autism
- ☐Y ☐N Aspergers
- ☐Y ☐N Blood clotting problems
- ☐Y ☐N Bronchitis
- ☐Y ☐N Cancer / Tumor or Growth
- ☐Y ☐N Crohn's Disease
- ☐Y ☐N Diabetes
- ☐Y ☐N Epilepsy
- ☐Y ☐N Fainting spells / seizures
- ☐Y ☐N Fever blisters / Herpes
- ☐Y ☐N Frequent headaches
- ☐Y ☐N Frequent dry mouth / Sjogren
- ☐Y ☐N Heart murmur / heart trouble
- ☐Y ☐N Hepatitis / Jaundice
- ☐Y ☐N High blood pressure
- ☐Y ☐N Hives / skin rash
- ☐Y ☐N Kidney / bladder trouble
- ☐Y ☐N Liver disease
- ☐Y ☐N Low blood pressure
- ☐Y ☐N Mental health problems
- ☐Y ☐N Mitral valve prolapse
- ☐Y ☐N Premedicate
- ☐Y ☐N Rheumatic Fever
- ☐Y ☐N Sinus trouble
- ☐Y ☐N Thyroid problems
- ☐Y ☐N Tuberculosis
- ☐Y ☐N Urinate frequently
- ☐Y ☐N Hearing problems
- ☐Y ☐N Speech problems
- ☐Y ☐N Hospital admissions
- ☐Y ☐N Other condition - see below

MEDICAL HISTORY

Is your child under a physician's care at this time? Yes ❑ No ❑ Date of your child's last physical exam? _____

Physician's name or name of medical practice? _____

Is your child taking any drugs or medications at this time? Yes ❑ No ❑ If yes, please list_____

_____

Please describe the general medical condition of your child?_____

_____

Does your child have any special needs? Yes ❑ No ❑ If yes, please explain _____

_____

Please describe any allergies that your child may have which were not mentioned above _____

_____

Please describe any medical concerns that your child may have which have not already been mentioned_____

_____

Please provide some more information for any medical alerts selected from the above checklist _____

_____

_____

THANK YOU FOR COMPLETING THE CHILD REGISTRATION AND PERSONAL HEALTH HISTORY

I acknowledge that the above information is correct to the best of my knowledge. It is my responsibility to inform the dental practice of any changes in my child's medical status.

Signature of Parent/Legal Guardian _____

Print Name_____

May we request release of your child's medical records for our reference? _____

Name of nearest relative or friend_____ Phone _____