CHILD REGISTRATION & MEDICAL HISTORY

1707 S. Oneida St.
Appleton, Wisconsin 54915
920-734-2392

Date ____________

Name ____________ (LAST) ____________ (FIRST) ____________ (MIDDLE) Birth Date ____________

Address ____________ Sex: M ___ F ___

City ____________ Zip Code ____________ Home Phone # ____________

School ____________

Hobbies ____________

Thumbsucking ____________ Mouth Breather ____________ Pacifier ____________

Child's Attitude Toward Dentistry? ____________

Father's Name ____________ Address ____________

City ____________ Zip Code ____________ Home # ____________ Cell # ____________

Father's Place of Employment ____________ Business # ____________

Mother's Name ____________ Address ____________

City ____________ Zip Code ____________ Home # ____________ Cell # ____________

Mother's Place of Employment ____________ Business # ____________

Insurance Information

Father's

Insurance Company Name: ____________

Address: ____________

Social Security Number: ____________ Birth Date: ____________

Group Number: ____________

Mother's

Insurance Company Name: ____________

Address: ____________

Social Security Number: ____________ Birth Date: ____________

Group Number: ____________

In case of an emergency—who may we notify other than immediate family?

Name ____________ Phone Number ____________

Address ____________ City, State & Zip Code ____________

Whom may we thank for referring you t ur office? ____________ ____________

HEALTH HISTORY

Child's Physician ______________________ Address ______________________ Phone ______________

Date of last physical examination ____

	YES	NO
Is child under care of physician now ______________	❑	❑
Is child receiving any medications 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	❑	❑
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	_____ Cerebral Palsy	_____ Diabetes	_____ Kidney	_____ Mononucleosis
_____ Asthma	_____ Chicken Pox	_____ Epilepsy	_____ Liver	_____ Mumps
_____ Autism	_____ Chronic Sinus	_____ Fainting	_____ Lung Disease	_____ Rheumatic Fever
_____ Bladder	_____ Convulsions	_____ Hearing	_____ Malignancies	_____ Thyroid
		_____ Heart	_____ Measles	_____ 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.

____

	YES	NO
If necessary, may we request release of your child's medical records for our reference ______________	❑	❑

CONSENT:

The undersigned hereby authorizes Doctor, after consulting with parent or guardian, to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to take a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) ______________________ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

Parent/Guardian ______________________________________ Date ______________