

child's registration & health history questionnaire

WELCOME TO BEDMINSTER FAMILY & COSMETIC DENTISTRY

You, as a parent, want to help your child to good oral health. Modern science is making many important contributions to better oral health, but the individual must still take the major responsibility for the care of his/her own mouth. You can teach your child to do so. With proper personal and professional care, your child may keep his/her teeth all his life.

CHILD'S NAME _____ DATE _____

SCHOOL _____ GRADE _____ DATE OF BIRTH _____ / _____ / _____
MONTH DAY YEAR

RESIDENCE _____

CITY _____ STATE _____ ZIP _____

FATHER'S NAME _____

ADDRESS _____ HOW LONG? _____

EMPLOYED BY _____ HOME PHONE/ _____
BUSINESS PHONE _____

ARE YOU ASSOCIATED WITH A DENTAL INSURANCE PLAN? _____ NAME OF INSURANCE COMPANY _____
POLICY # _____
UNION (LOCAL#) _____ UNION HEAD _____

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT _____

ANY BROTHERS OR SISTERS? _____ LIST AGES _____

IS THIS YOUR CHILD'S FIRST DENTAL EXPERIENCE? _____

WHAT IS THE CHILD'S ATTITUDE TOWARDS THIS VISIT? _____
COMMENTS: _____

HOW DID YOU FIRST HEAR ABOUT BEDMINSTER FAMILY & COSMETIC DENTISTRY? _____
THANK YOU

LAST NAME _____ FIRST NAME _____

DATE OF EXAM _____

Bedminster Family & Cosmetic Dentistry

MEDICAL HEALTH HISTORY

General health
 Excellent good fair poor

Who is child's physician?
 Address _____

When did child have last complete physical examination?

Is child being treated for anything now?

Did child ever have
 Kidney disease Anemia
 Diabetes Asthma
 Rheumatic fever Heart trouble
 Hepatitis Epilepsy/convulsions
 Liver disease Speech impediment
 Tuberculosis Hearing problem
 Other _____

	Yes	No
Is child allergic to <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Novocaine <input type="checkbox"/> Other		
Is child taking any medication now? if so, what?		
Does child have any allergies?		
Is child subject to prolonged bleeding?		
Does child have any emotional problems?		
PARENT'S SIGNATURE _____		
PARENT'S SOCIAL SECURITY NO. _____		

DENTAL HEALTH HISTORY – CHILD

Date of last dental exam _____

What concerns you most about your child's dental health?

Does your child ever have dental pain? If so, when?

Did you child ever have a negative dental experience?
 Discuss _____

Mouth habits:
 Thumb sucking Mouth breathing Bottle nursing

Has the child had teeth removed?

Has the child had orthodontic treatment?

Does your child have a "sweet" tooth?

How often does your child brush?
 Floss?

Has child received any fluoride treatment?
 Pill/vitamins Topical Water

Are you happy with the appearance of child's teeth?

Has anyone explained the importance of primary teeth?
