Email Address:

_____

CHILD'S REGISTRATION AND HISTORY

DATE _____

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

SCHOOL _____ GRADE _____ RESIDENCE ADDRESS _____

CITY _____ STATE _____ ZIP _____

FATHER'S NAME _____ MOTHER'S NAME _____

FATHER EMPLOYED BY _____ CELL _____ HOME _____ BUS _____

MOTHER EMPLOYED BY _____ CELL _____ HOME _____ BUS _____

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

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

PARENT'S SOCIAL SECURITY NUMBER _____

DENTAL INSURANCE COVERAGE/NAME OF CARRIER _____

WHOM MAY WE THANK FOR REFERRING YOU _____

WHAT IS CHILD'S FAVORITE SPORT _____ FAVORITE TOY _____

FAVORITE HOBBY _____ FAVORITE PERSON _____ FAVORITE FICTION CHARACTER _____

DENTAL HISTORY

Date of last visit to a dentist _____

For what service _____

_____

	YES	NO
Has child complained about dental problems _____	❑	❑
Any unhappy dental experiences _____	❑	❑
Any injuries to mouth - teeth - head _____	❑	❑
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____	❑	❑
Any unusual speech habits _____	❑	❑
Any lost teeth _____	❑	❑
Have missing teeth been replaced _____	❑	❑
Orthodontic appliances worn now or ever been _____	❑	❑

	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 flouride taken in any form _____	❑	❑
Child's attitude to dentistry _____		
Do you desire complete dental 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 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 (doctor's use) _____

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

____Anemia	____Chronic Sinus	____Hearing	____Mastoid	____Thyroid
____Asthma	____Convulsions	____Heart	____Measles	____Tuberculosis
____Bladder	____Diabetes	____Kidney	____Mononucleosis	____Other
____Cerebral Palsy	____Epilepsy	____Liver	____Mumps	____Venereal Disease
____Chicken Pox	____Fainting	____Malignancies	____Rheumatic Fever	

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 discusssed.

	YES	NO
May we request release of your child's medical records for our reference	❑	❑

I give my full consent to Martin V. Chaney, DMD and his staff to render dental care to the named above and agree that I am ultimately the party responsible for paying any and all fees incurred.

Signature: _____