



Patient Registration: Dental and Medical Health History

Please complete this registration form. If you have any question, please ask.

Patient's Name _____ Date of Birth _____ Today's Date _____
First Name Last Name Month / Date / Year Month / Date / Year

Dental History

- 1. Is this your child's first dental visit? Yes No _____
Previous Dentist's Name
- 2. Has your child ever had problems receiving dental care? Yes No _____
Explain Problem(s)
- 3. Is there a particular problem with your child's teeth that prompted you to bring him/her to our office? Yes No _____
Explain Problem(s)
- 4. Who brushes the child's teeth at home? _____
Who Brushes? How Often?
- 5. Is the patient receiving fluoride in any form? Yes No _____
Type of Treatment

Medical History

Physician's/Clinic Name _____ Phone (_____) _____

Address _____
Street City State Zip

- 1. If needed for dental treatment, may we have your permission for our dentist to consult with this physician? Yes No _____
Special Instructions
- 2. Is your child receiving the recommended vaccinations for childhood diseases? Yes No _____
Explain Problem(s)
- 3. Please describe any medical conditions that are of present concern (*medications, pending surgery, recent injuries, issues related to healthcare*)

- 4. Is the patient being treated by a physician at this time? Yes No _____
Please Describe
- 5. Is the patient taking any medicines at this time? Yes No _____
Please List Medications

Medications
- 6. Has the patient ever been admitted to a hospital? Yes No _____
Please Describe
- 7. Has the patient ever received general anesthesia/sedation? Yes No _____
Please Describe
- 8. Is the patient allergic to any medicines, substances or foods? Yes No _____
Please Name Allergy Source
- 9. Has the patient ever had a blood transfusion? Yes No _____
Please Describe
- 10. Has the patient ever been abused? (*Physical, emotional, sexual*) Yes No _____
Please Describe

Birth History

- 1. Full term Yes No _____
Explain Problem(s)
- 3. Low Birth Weight Yes No _____
Explain Problem(s)
- 4. Complications Yes No _____
Explain Problem(s)
- 5. Neo-Natal Illness Yes No _____
Explain Problem(s)

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Medical History *(continued)*

Please review the following groups of questions. Indicate if there is a current health problem, or if there was a problem in the past for your child.

Blood, Heart and Liver Organ Systems

- Anemia Yes No _____
- Hemophilia Yes No _____
- Sickle Cell Anemia Yes No _____
- Heart Problem Yes No _____
- Hepatitis Yes No _____
- AIDS Yes No _____
- Rheumatic Fever Yes No _____
- Leukemia Yes No _____
- Other _____

Eyes, Ears, Nose, Throat and Pulmonary Organ Systems

- Eye Problems Yes No _____
- Hearing Problems Yes No _____
- Frequent Ear Infections Yes No _____
- Asthma Yes No _____
- Mouth Breathing Yes No _____
- Frequent Sore Throat Yes No _____
- Sinus Problems Yes No _____
- Snoring at Night Yes No _____
- Cleft Lip/Palate Yes No _____
- Tuberculosis Yes No _____
- Bronchitis Yes No _____
- Pneumonia Yes No _____
- Other _____

Kidney, Bladder, Renal Organ Systems

- Renal Disease Yes No _____
- Frequent Infections Yes No _____
- Other _____

Endocrine and Glands

- Diabetes Yes No _____
- Thyroid Problems Yes No _____
- Other _____

Muscles and Nervous System

- Cerebral Palsy Yes No _____
- Convulsions/Seizures Yes No _____
- Epilepsy Yes No _____
- Spina Bifida Yes No _____
- Other _____

Bones

- Orthopedic Problems Yes No _____
- Rickets Yes No _____
- Scoliosis Yes No _____
- Other _____

Psychological and Emotional

- Clinical Depression Yes No _____
- ADD (*Attention Deficit Disorder*) Yes No _____
- Autism Yes No _____
- Brain Injury Yes No _____
- Mental Retardation Yes No _____
- Behavioral Issues Yes No _____
- Other _____

Childhood Disease History

- Chicken Pox Yes No _____
- Measles Yes No _____
- Mumps Yes No _____
- Other _____

Adolescent/Teen Social Issues that Can Affect Dental Health

- Pierced Lips/Tongue Yes No _____
- Smoking Yes No _____
- Alcohol Yes No _____
- Eating Disorders Yes No _____
- Substance Abuse Yes No _____
- Oral Infections Yes No _____
- Pregnancy Yes No _____
- Other _____

Signature _____ Parent/Guardian _____ Relationship with Child _____

Summary/Comments *(For Doctor's Use Only)*

