# PATIENT REGISTRATION

Patient Name_____Date of Birth_____Sex_____Phone # (_____)_____
Home Address _____ Mailing Address _____
Name, Address, Telephone and E-mail Address of Legal Guardian _____
_____
Whom may we thank for referring you to our office? _____
List the names of other immediate family members who are patients at Kids Dental Experts_____
_____
School Attending _____ Favorite interest/hobby _____
Nickname_____

## PARENT / GUARDIAN INFORMATION

Father's Name _____ Mother's Name _____
E-mail Address_____ E-mail Address_____
Address (if different from patient) _____ Address (if different from patient) _____
_____ _____
Phone #_____Cell # _____ Phone #_____Cell # _____
Birthdate_____Social Security #_____ Birthdate_____Social Security #_____
Employer and Position_____ Employer and Position_____

Parents' Marital Status: ___Married ___Divorced ___Single ___Widowed ___Separated

Stepmother's Name_____ Stepfather's Name_____
E-mail Address_____ E-mail Address_____
Address (if different from patient) _____ Address (if different from patient) _____
Phone #_____Cell # _____ Phone #_____Cell # _____
Birthdate_____Social Security #_____ Birthdate_____Social Security #_____
Employer and Position_____ Employer and Position_____

## MEDICAL HISTORY

Child's Physician_____ Hospital/Clinic_____ Phone # (_____)_____
Date of last physical examination_____Results _____

| | Yes | No |
|---|---|---|
| Is child under the care of a physician? Explain_____ | ☐ | ☐ |
| Is child receiving any medications or drugs? List and Explain reason for taking:_____ | ☐ | ☐ |
| Has your child ever been hospitalized? Explain_____ | ☐ | ☐ |
| Any excessive or prolonged bleeding when cut? Explain_____ | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Has your child ever had surgery? Explain_____ | ☐ | ☐ |
| Is your child allergic to any of the following? ☐ Penicillin ☐ Latex products ☐ Local anesthetic Other drugs (list)_____ | ☐ | ☐ |
| Does your child have good physical coordination? | ☐ | ☐ |
| Are there any emotional problems? Explain_____ | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Does your child frequently encounter stressful situations at home or school? Explain_____ | ☐ | ☐ |

Please describe any current medical information we need to be aware of that has not been covered. (such as pending surgeries or recent injuries)
_____
_____

### Please check if child has any history of difficulty with any of the following:

___ADD (Attention Deficit Disorder)
___ADHD (Attention Deficit Hyperactive Disorder)
___AIDS (HIV)
___Anemia
___Arthritis
___Anorexia
___Asthma _____frequency of attacks
____exercise induced
___Autism
___Bladder
___Blood pressure concerns
___Blood transfusion
Explain_____
___Bruises easily
___Chicken Pox
___Convulsions/Epilepsy/Seizures
___Depression
___Diabetes
___Fainting spells
___Hearing impaired
___Heart condition
Explain_____
(your child may require antibiotic before dental treatment)
___Hepatitis Type A B C Other____
___Hives or skin rash
___Liver disease
___Malignancies
___Mastoid
___Measles
___Mononucleosis
___Mumps
___Nervousness
___Persistent cough or coughs up blood
___Rheumatic fever
___Thyroid
___Tuberculosis
___Venereal disease
___Surgery or radiation treatment for tumor, growth or condition of the head or neck

See Reverse

## DENTAL HISTORY

Most important dental concern _____

Date of last dental visit _____ Type of Service _____

| | YES | NO |
|---|---|---|
| Has your child complained about dental problems? (Explain) | ☐ | ☐ |
| Any problem associated with previous dental treatment? (Explain) | ☐ | ☐ |
| Any unhappy dental experiences? (Explain) | ☐ | ☐ |
| Has your child had any injuries to the mouth, teeth or head? (Explain) | ☐ | ☐ |

How would you describe your child's attitude toward dentistry? _____

### Please check the following to indicate "Yes" regarding this patient.

___apthous ulcers frequent (canker sores)
___breath odor
___herpetic lesions frequent (cold sores)
___earaches
___headaches
___jaws make a clicking, grinding or popping noise
___neck pain
___orthodontic concerns (crooked teeth or bite)
___snore at night
___speech impaired/unusual speech habits
___teeth grinding
___teeth clenching
___mouthbreathing
___nail biting
___lip biting or sucking
___nursing or bottle habit
___pacifier____frequent___occasionally
___self induced purging (bulimia)
___thumbsucking___frequent___occasionally
___finger sucking___frequent___occasionally
___smoking
___chewing tobacco
___frequent consumption of carbonated beverages
___strong gag reflex
___frequent vomiting

### Fluoride/Decay Risk Assessment

| | Yes | No | Unsure |
|---|---|---|---|
| Is fluoride taken in any form? | ☐ | ☐ | ☐ |
| Is fluoride in your water supply? | ☐ | ☐ | ☐ |
| *(Green Bay city water is fluoridated)* | | | |
| Number of days in daycare_____ | | | |
| Fluoride toothpaste/rinse used | ☐ | ☐ | ☐ |
| History of decay in family? | ☐ | ☐ | ☐ |

| | Yes | No | Unsure |
|---|---|---|---|
| Mother's side? | ☐ | ☐ | ☐ |
| Father's side? | ☐ | ☐ | ☐ |
| Brothers or Sisters with decay? | ☐ | ☐ | ☐ |

| | Yes | No | Unsure |
|---|---|---|---|
| Does your child brush teeth daily? | ☐ | ☐ | ☐ |
| How many times each day?_____ | | | |
| Do your child's teeth get flossed daily? | ☐ | ☐ | ☐ |
| How many times each day?_____ | | | |

How do you feel about preserving baby teeth? ____Important ____Not important ____No opinion

*** * * PLEASE COMPLETE THIS SECTION IF CHILD IS 18 MONTHS OR YOUNGER * * ***

### Birth History

Birth Length _____inches
___Full Term
___Premature _____ Weeks
___Normal Delivery
___Caesarean Section
___Forceps Delivery
___Complications during delivery
Explain:_____

Did your infant experience any of the following during the first few weeks of life?
____jaundice ____breathing difficulties
____feeding difficulties ____high fevers
____serious illness ____intubation
____other_____

Did you experience any of the following during pregnancy?
____severe morning sickness
____physical trauma or injury
____medications taken Explain_____
Illness *(not including colds or flu)*_____

### Feeding History *(Please check all that apply.)*

____Breast feeding
How long? ____years ____months
Schedule frequency:
____on-demand feeding
____bedtime
____supplemental bottle
Began when? ____months
____weaned____months
____currently breast feeding

____Bottle feeding
____ready to feed formula
____formula reconstituted with water
Average time of each feeding_____
____bedtime bottle
Contents of bottle_____
____bottle is used as a pacifier
Contents of bottle_____
____weaned from bottle____months

Notes:

I have completed the requested information on this form to the best of my knowledge.

Date_____ Signature_____Relationship to child _____