WATER TOWER DENTAL ltd

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CHILD REGISTRATION

Welcome to our office. Please complete this medical history form so we may be aware of your child's past or present health conditions. This office uses the pronouns, "my" and "your", on this form, to refer to a child in your care. Thank you.

Patient's name ____
LAST FIRST MIDDLE

Nickname _______________ Date of Birth _______________ Social Security no. (if applicable) ______________________

Sex: ☐ M ☐ F ☐ Prefer to self-describe ____

Parent/guardian name ____ Relationship to patient ________________

Mailing Address ____
STREET CITY STATE ZIP

Cell Phone ______________________ Home Phone ______________________ Work Phone ______________________

Preferred contact number: ☐ Cell ☐ Home ☐ Work

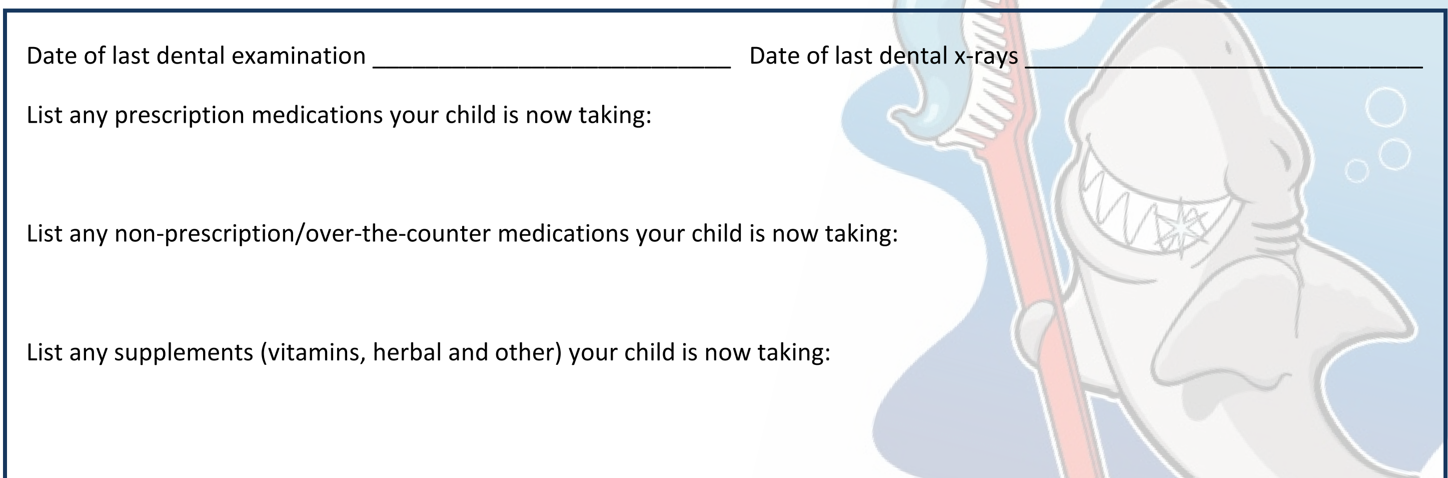
Person responsible for bill ____ Relationship to patient ________________

Purpose of today's visit ____

Child's Primary Care Physician ____ Date of Last Visit ________________

Physician's Address ____ Physician's Phone Number ________________

CHILD MEDICAL HISTORY



Date of last dental examination ________________________ Date of last dental x-rays ________________________

List any prescription medications your child is now taking:

List any non-prescription/over-the-counter medications your child is now taking:

List any supplements (vitamins, herbal and other) your child is now taking:

Please check Yes or No or fill in where appropriate:

Has your child complained about dental problems? ☐ Yes ☐ No

If Yes, please describe ______

Do you have any specific concerns about your child's dental health? ☐ Yes ☐ No

If Yes, please describe ______

Has your child had any problems with dental treatment in the past? ☐ Yes ☐ No

Has your child ever worn orthodontic appliances? ☐ Yes ☐ No

If Yes, please describe ______

Does your child receive all recommended vaccinations? ☐ Yes ☐ No

If no, please explain ______

Has your child ever reacted to immunizations? ☐ Yes ☐ No

Has your child had a serious illness? ☐ Yes ☐ No

If Yes, when? ______ Please describe ______

Has your child been hospitalized or had surgery? ☐ Yes ☐ No

If Yes, please describe ______

Does your child have a history of any other illness? ☐ Yes ☐ No

If Yes, please describe ______

Is your child currently being treated for any illness? ☐ Yes ☐ No

Does your child have speech difficulties? ☐ Yes ☐ No

Is your child physically, mentally, or emotionally impaired? ☐ Yes ☐ No

What type of water does your child drink? ☐ City ☐ Well ☐ Bottled ☐ Filtered

Does your child take fluoride supplements? ☐ Yes ☐ No

How many times each day are your child's teeth brushed? ______ Flossed? ______ Do you assist? ☐ Yes ☐ No

Are your child's teeth sensitive to any of the following:

Hot or cold? ☐ Yes ☐ No Sweets? ☐ Yes ☐ No Biting or chewing? ☐ Yes ☐ No

Please indicate any of the items below that apply to your child.

☐ Injury to head, mouth, or teeth
☐ Clenching jaw
☐ Chewing hard objects (e.g. pencils)
☐ Pain or tenderness in the jaw joint, ear, side of face
☐ Grinding of teeth
☐ Biting or sucking lips or cheeks
☐ Oral habits: thumb/finger sucking, nail biting
☐ Bleeding gums
☐ Problems with eruption or shedding teeth
☐ Experiences excessive bleeding when cut
☐ Mouth breathing

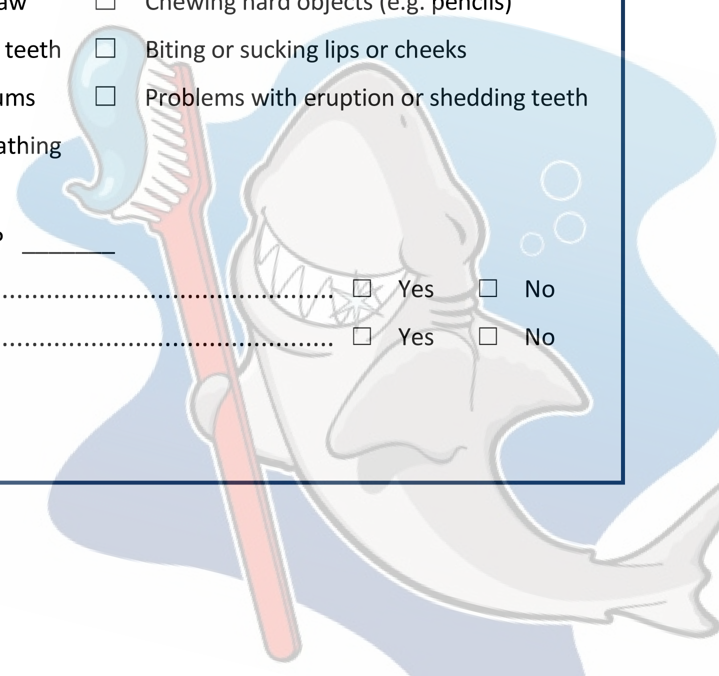
Is your child still nursing? ☐ Yes ☐ No ☐ Breast ☐ Bottle

At what age did your child stop bottle feeding? ______ Breast feeding? ______

Does your child currently use a pacifier? ☐ Yes ☐ No

Does your child participate in active recreational activities? ☐ Yes ☐ No

Please explain any of the items checked above:



Please check any of the medical conditions, diseases or problems below that your child has had or currently has.

☐ Allergies or hives	☐ Anemia	☐ Asthma, sinus trouble or hay fever
☐ Behavioral/learning problems	☐ Blood transfusion	☐ Congenital heart disease
☐ Bone/Joints problems	☐ Bruise easily	☐ Cancer or tumors
☐ Cold sores/fever blisters/herpes	☐ Cerebral palsy	☐ Chicken pox
☐ Diabetes	☐ Dizziness or fainting spells	☐ Epilepsy, convulsions, or seizures
☐ Frequent ear or throat infections, colds	☐ Growth problems	☐ Hyperactivity
☐ Frequent headaches or migraines	☐ Hearing impairment	☐ Heart condition, defects, murmur
☐ Hemophilia/bleeding disorder	☐ Hepatitis ☐ A ☐ B ☐ C	☐ HIV or AIDS
☐ Kidney problems	☐ Liver problems	☐ Measles
☐ Mononucleosis	☐ Mumps	☐ Neurological disorder
☐ Sickle cell anemia	☐ Thyroid problems	☐ Tuberculosis
☐ Radiation therapy/chemotherapy	☐ Respiratory problems	☐ Rheumatic fever

Please explain any checked answers above or other problems not listed:

Has your child had allergies or reactions to any of the following?

Local anesthetics (novocaine, lidocaine, xylocaine) .... ☐ Yes ☐ No

Latex (gloves, balloons) .... ☐ Yes ☐ No

Metals (jewelry, clothing snaps) .... ☐ Yes ☐ No

Penicillin .... ☐ Yes ☐ No

Other antibiotics (if so, please list here ____) ☐ Yes ☐ No

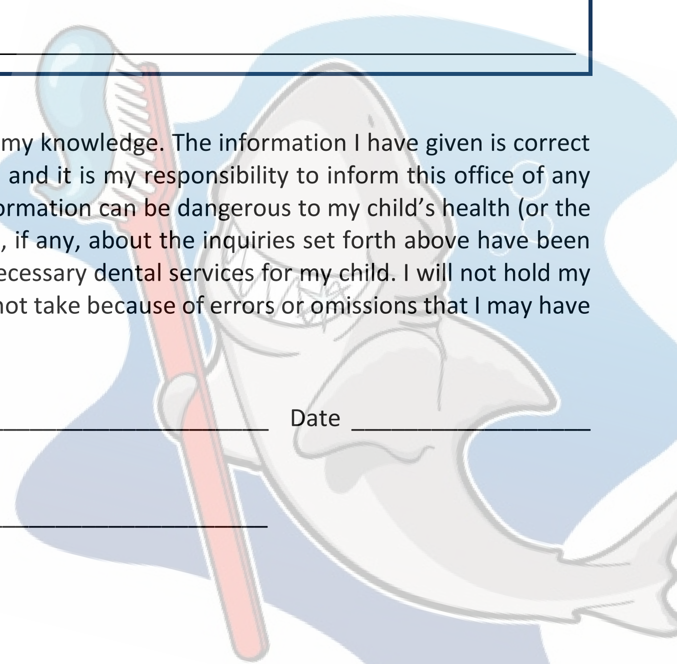
Anti-inflammatory medications such as ibuprofen (Advil, Motrin), naproxen (Aleve), or aspirin .... ☐ Yes ☐ No

Other medications, non-prescription medications, supplements, or substances:

____

Is your child allergic to anything else, such as certain foods? .... ☐ Yes ☐ No

If yes, please describe ____



I certify that I have read and understand the above information to the best of my knowledge. The information I have given is correct to the best of my knowledge and it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I understand that providing incorrect information can be dangerous to my child's health (or the health of a child for whom I am a guardian). I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I authorize the doctor and staff to perform the necessary dental services for my child. I will not hold my dentist, or any member of the staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of parent or guardian ____ Date ______________

Print Name ____