CHILD REGISTRATION FORM

Child's Name____ Nickname_________________Age__________Birth Date________________

Child's Interests____

Address____City_______________________State_____ Zip__________

Cell Phone________________________ Home Phone________________________

Father's Name_______________________________________SSN__________________Employer______________________________________

Mother's Name___________________________________SSN__________________Employer______________________________________

Person Financially Responsible__________________________________ Dental Insurance____

In case of emergency or traumatic injury, I authorize Dr. Goyette to treat my child in my absence, as he deems necessary.

Signature____

MEDICAL HISTORY

Name of child's physician____ Is child under care of physician now? Yes/No

Has child ever been hospitalized? Yes/No

Has child ever had surgery? Yes/No If yes, please explain____

Is your child receiving any medications, drugs or supplements?____

Has the child been told by a physician to premedicate before dental procedures? Yes/No If yes, please explain __________________________

Is there any allergy to penicillin or other drugs?__________________ Other allergies (latex, food, pollen, dust, other) ____________________

Is there any excessive bleeding when cut? Yes/No Are there any emotional problems? Yes/No

Has child had any history of or difficulty with any of the following:

___Anemia ___Aids ___Asthma ___Bladder ___Canker Sores ___Cerebral Palsy
___Chicken Pox ___Cold Sores ___Convulsions ___Diabetes ___Epilepsy ___Fainting
___Hearing ___Heart ___Hepatitis ___Kidney ___Malignancies ___Mastoid
___Measles ___Mononucleosis ___Mumps ___Rheumatic Fever ___Thyroid ___Venereal Disease
___Tuberculosis

Please describe any medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of:

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DENTAL HISTORY

Date of last visit to a dentist ____________________________________ For what service ____

Any unhappy dental experiences Yes/No
Any injuries to mouth, teeth, head Yes/No
Any unusual speech habits Yes/No
Any mouth habits – thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. Yes/No

Does your child brush teeth daily Yes/No
Do you assist child with tooth brushing Yes/No
Is dental floss used Yes/No
Is fluoride taken in any form Yes/No

Child's attitude towards dentistry
____
____

Has child complained about dental problems/sensitivity? Yes/No

____ ________________________________

Parent's Signature Date