Child's Registration and Health History (ages 12 and below)

Child's profile: **Date**_____

Name _____ Birthdate _____/ _____/ ____
first middle last

Mailing address _____
street/apt# city state zip

Daytime phone # _____ relative/friend phone # _____

SSN# _____ MaineCare # _____

Family information:

Primary parent/guardian _____

Mother's name _____ day phone # _____

Employer _____ how long _____ phone # _____

Father's name _____ day phone # _____

Employer _____ how long _____ phone # _____

Medical Insurance Company _____subscriber # _____ group# _____

Address of Medical Insurance Company _____

Dental Insurance Company _____ subscriber # _____ group# _____

Address of Dental Insurance Company _____

Dental history:

Date of last dental visit _____

What was done _____

Has child complained about dental problems_____

What _____

Any unhappy dental experiences _____

_____

Any injuries to mouth, teeth, head, etc _____

Mouth habits: thumb sucking, nail biting, mouth breathing, nursing or baby bottle habits, pacifier, etc. _____

Any unusual speech habits _____

Does child brush teeth daily _____

Do you help with the brushing _____

How often _____

Does child use dental floss _____

How often _____

Does child use disclosing tablets _____

Does child use fluoride _____

Child's attitude towards dentistry _____

_____

Do you desire complete dental service for your child ____

_____

Any lost teeth _____

Have missing teeth been replaced _____

Orthodontic appliances worn now or ever been _____

Summary (for doctor's use)

Health history:

Child's physician _____
Physician's address _____phone _____

Date of last exam_____
Results of last exam _____

Have you been told that your child has any problems with their heart, lungs, stomach, liver, kidneys? (circle if yes)
If circled explain: _____
_____

Are your child's vaccinations up to date? Yes_____ No_____

Is child under care of physician now _____ Are there any emotional problems _____

Why _____ What _____

Is child receiving any medication or drugs _____ Does child have good physical coordination _____

Is child allergic to penicillin or other drugs _____

Has child ever been hospitalized _____ Summary (for doctor's use)

When _____

Why _____

Is there any excessive bleeding when cut _____

Does child have allergies to food, pollen, animals,
dust, other _____

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

__ Anemia	__ Chronic sinus	__ Fainting	__ Liver	__ Mumps	__Venereal disease
__ Asthma	__ Convulsions	__ Heart	__ Mastoid	__ Rheumatic fever	__ Other
__ Bladder	__ Diabetes	__ Hearing	__ Mononucleosis	__ Tuberculosis	

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 discussed.

_____

May we request release of you child's medical records for our reference ___YES ___NO

I hereby authorize payment of dental benefits otherwise payable to me directly to Family Preventive Dental Care, P.A.
Signature _____

This information was discussed with and given by _____

Relation to child _____ Date _____