

Child's Name \_\_\_\_\_  
LAST FIRST INITIAL

Date of birth \_\_\_\_\_

Nickname \_\_\_\_\_

Male Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_

School \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_

Mother/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

SS# \_\_\_\_\_ Date of birth \_\_\_\_\_

Father/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

SS# \_\_\_\_\_ Date of birth \_\_\_\_\_

Dental Insurance Carrier \_\_\_\_\_

Name of Subscriber \_\_\_\_\_

Subscriber ID# \_\_\_\_\_ Group# \_\_\_\_\_

Secondary Insurance Coverage, if any \_\_\_\_\_

Whom may we thank for referring you \_\_\_\_\_

What is child's favorite sport \_\_\_\_\_ toy \_\_\_\_\_

hobby \_\_\_\_\_ person \_\_\_\_\_ fictional character \_\_\_\_\_

Date of last visit to a dentist \_\_\_\_\_

For what service \_\_\_\_\_

Has child complained about dental problems \_\_\_\_\_

Any unhappy dental experiences \_\_\_\_\_

Any injuries to mouth - teeth - head \_\_\_\_\_

Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. \_\_\_\_\_

Any unusual speech habits \_\_\_\_\_

Any lost teeth \_\_\_\_\_

Have missing teeth been replaced \_\_\_\_\_

Orthodontic appliances worn now or ever been \_\_\_\_\_

**DENTAL HISTORY**

Yes No

Does your child brush teeth daily \_\_\_\_\_

Do you assist child with tooth brushing \_\_\_\_\_

How often \_\_\_\_\_

Is dental floss used \_\_\_\_\_

How often \_\_\_\_\_

Are disclosing tablets used \_\_\_\_\_

Is fluoride taken in any form \_\_\_\_\_

Do you desire complete dental service for the child \_\_\_\_\_

Child's attitude to dentistry \_\_\_\_\_

Summary (for doctor's use) \_\_\_\_\_

**HINGHAM DENTAL ASSOCIATES  
CHILD REGISTRATION**

**HEALTH HISTORY**

Were there any difficulties during the pregnancy, delivery (e.g., prematurity) or 1<sup>st</sup> year of your child's life?

If yes, describe? \_\_\_\_\_ Yes  No

**Medical conditions:** Does your child have any history of the following? (Check all that apply)

<p><b>General conditions</b></p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Gastrointestinal disorders</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> Kidney disease</p> <p><input type="checkbox"/> Rheumatic fever</p> <p><b>Behavior/Learning</b></p> <p><input type="checkbox"/> ADHD</p> <p><input type="checkbox"/> Anxiousness/Nervousness</p> <p><input type="checkbox"/> Autism</p> <p><input type="checkbox"/> Behavior issues: Type _____</p> <p><input type="checkbox"/> Emotional disability: Type _____</p> <p><input type="checkbox"/> Learning disability: Type _____</p> <p><input type="checkbox"/> Psychiatric disorder: Type _____</p>	<p><b>Developmental</b></p> <p><input type="checkbox"/> Brain injury</p> <p><input type="checkbox"/> Cerebral palsy</p> <p><input type="checkbox"/> Cleft lip/palate</p> <p><input type="checkbox"/> Developmental Delay</p> <p><input type="checkbox"/> Feeding/Eating problems</p> <p><input type="checkbox"/> Growth problems</p> <p><input type="checkbox"/> Hearing loss: Type _____</p> <p><input type="checkbox"/> Neuromuscular defect</p> <p><input type="checkbox"/> Orthopedic problems</p> <p><input type="checkbox"/> Seizures: Type _____</p> <p><input type="checkbox"/> Speech prob: Type _____</p> <p><input type="checkbox"/> Spina bifida</p> <p><b>Hematological (Blood-related)</b></p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Bleeding (prolonged)</p> <p><input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> Sickle cell trait</p> <p><input type="checkbox"/> Sickle cell disease</p> <p><input type="checkbox"/> Transfusion of blood</p>	<p><b>Infectious</b></p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> HIV infection (AIDS)</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Venereal disease: Type _____</p> <p><b>Substance use/Abuse</b></p> <p><input type="checkbox"/> Drug use</p> <p><input type="checkbox"/> Tobacco use</p> <p><input type="checkbox"/> Abuse (physical or sexual)</p> <p><b>Other</b></p> <p><input type="checkbox"/> Cancer: Type _____</p> <p><input type="checkbox"/> Leukemia: Type _____</p> <p><input type="checkbox"/> Fainting/headaches (often)</p> <p><input type="checkbox"/> Sleep apnea</p> <p><input type="checkbox"/> Sleep problems</p> <p><input type="checkbox"/> Snoring</p> <p><input type="checkbox"/> Syndrome: Type _____</p> <p><input type="checkbox"/> Other _____</p>
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If any boxes checked, please describe further: \_\_\_\_\_

\_\_\_\_\_

**Medications:** Is your child CURRENTLY taking any medications?

Drug	How much & how often?	Reason

Allergies: Has your child had any allergic reactions to:

Medications or drugs? \_\_\_\_\_

Latex? \_\_\_\_\_

Foods? \_\_\_\_\_

Other? \_\_\_\_\_

May we request release of your child's medical records for our reference \_\_\_\_\_ Yes  No

This information was discussed with and given by \_\_\_\_\_

Relation to child \_\_\_\_\_

**Parent (Guardian) Signature** \_\_\_\_\_ **Date** \_\_\_\_\_