Child's Name _____ **Date of birth** _____
LAST FIRST INITIAL

Nickname _____ **Male** **Female**

Address _____

City _____ State _____ Zip _____

Home Phone: _____

School _____

Address _____ Grade _____

Father/Guardian Name _____

Address _____

City _____ State _____ Zip _____

Home _____ Work _____ Cell _____

SS# _____ Date of birth _____

Mother/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 _____

DENTAL HISTORY

Date of last visit to a dentist _____

For what service _____

_____

	Yes	No
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 _____	☐	☐

	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 1st 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)

General conditions

- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Gastrointestinal disorders
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Kidney disease
- ☐ Rheumatic fever

Behavior/Learning

- ☐ ADHD
- ☐ Anxiousness/Nervousness
- ☐ Autism
- ☐ Behavior issues: Type_____
- ☐ Emotional disability: Type_____
- ☐ Learning disability: Type_____
- ☐ Psychiatric disorder: Type_____

Developmental

- ☐ Brain injury
- ☐ Cerebral palsy
- ☐ Cleft lip/palate
- ☐ Developmental Delay
- ☐ Feeding/Eating problems
- ☐ Growth problems
- ☐ Hearing loss: Type_____
- ☐ Neuromuscular defect
- ☐ Orthopedic problems
- ☐ Seizures: Type_____
- ☐ Speech prob: Type _____
- ☐ Spina bifida

Hematological (Blood-related)

- ☐ Anemia
- ☐ Bleeding (prolonged)
- ☐ Hemophilia
- ☐ Sickle cell trait
- ☐ Sickle cell disease
- ☐ Transfusion of blood

Infectious

- ☐ Hepatitis
- ☐ HIV infection (AIDS)
- ☐ Tuberculosis
- ☐ Venereal disease: Type_____

Substance use/Abuse

- ☐ Drug use
- ☐ Tobacco use
- ☐ Abuse (physical or sexual)

Other

- ☐ Cancer: Type_____
- ☐ Leukemia: Type_____
- ☐ Fainting/headaches (often)
- ☐ Sleep apnea
- ☐ Sleep problems
- ☐ Snoring
- ☐ Syndrome: Type _____
- ☐ Other _____

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** _____