Child Dental and Medical History

CHILD INFORMATION

Child Registration Form:

Name ____

First Name Middle Initial Last Name Preferred Name

Street Address ____

City, State, Zip code, ____

Birth Date__________ Age _______ Male______ Female ________

PARENT INFORMATION:

Parent name. ____

Parent's address if different from child's,____

Phone numbers:

Home ________________ Work ______________________Cell ___________________________

Parent email address for appointment verification and reminders:

Parent social security number ____________________ Parent birth date ________________

Employer ____

Employer's address ____

Occupation ____

Dental Insurance Information: (If applicable)

Employer who carries policy, ____

Name of dental insurance company ____

Dental insurance company claim address, ____

Group number for policy, ____

Name of policy holder (parent), ____

Policyholder's social security number ____

Policyholder's birth date, ____

In case of emergency, who should be notified?, ______________________________________

Dental history: Date of last dental exam. ____

Date of last dental x-rays. ____

Has your child had difficulties associated with previous dental treatment?

If yes, explain, ____

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

_____Injury to mouth or teeth _____ Oral habits: thumb sucking, nail biting

_____ Frequent ulcers or blisters ____ Sensitive/painful teeth

_____ Grinding of teeth ____ Bleeding gums____Recurrent/frequent headaches

HIGH DESERT DENTAL

Joshua Eastham, DMD

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Medical History:

Has your child had any of the following medical conditions:

_______ Heart murmur
_______ Diabetes
_______ Hepatitis/jaundice
_______ Asthma
_______ Cancer /tumors
_______ Mental handicap
_______ Hearing impairment
_______ Hyperactive
_______ Surgeries
_______ Premature birth
_______ Congenital heart disease
_______ HIV Virus/AIDS
_______ Convulsions/epilepsy
_______ Rheumatic fever
_______ Kidney/liver problems
_______ Physical handicap
_______ Speech impairment
_______ Hospitalization
_______ Tuberculosis

Explain any "Yes" answers above or other problems not listed:. ______________
____

List any drugs your child is now taking:. ____

List any drugs your child is allergic to:. ____

Child's physician____

Signature of parent completing this form

____

OFFICE USE ONLY Medical History Update:

Child Dental and Medical History

Date	Exceptions	No Change	Patient’s Signature	Reviewed by:
_________	____________	____________	______________________	____________
_________	____________	____________	______________________	____________
_________	____________	____________	______________________	____________
_________	____________	____________	______________________	____________
_________	____________	____________	______________________	____________
_________	____________	____________	______________________	____________

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DENTAL
Joshua Eastham, DMD