

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). Medicaid

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
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Medical History:

Has your child had any of the following medical conditions:

- | | |
|---|---|
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Congenital heart disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Virus/AIDS |
| <input type="checkbox"/> Hepatitis/jaundice | <input type="checkbox"/> Convulsions/epilepsy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer /tumors | <input type="checkbox"/> Kidney/liver problems |
| <input type="checkbox"/> Mental handicap | <input type="checkbox"/> Physical handicap |
| <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Speech impairment |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Hospitalization |
| <input type="checkbox"/> Surgeries | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Premature birth | |

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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