Piedmont Family Dentistry
181 W. WILKES MEDICAL CENTER RD.
FERGUSON, NC 28624
336-973-5060

CHILD REGISTRATION AND HEALTH HISTORY ____/_____/_____ **Date**

First Name **(MI)** **Last Name** **Nickname** **Birth Date** **Age**

Address **City** **State** **Zip Code**

School **Address** **Grade**

Mother's Details ☐ **Primary Contact**

Name **Home Phone** **Cell Phone**

Employment **Work Phone**

Social Security No. **Driver's License No./ State** **Birth Date**

Father's Details ☐ **Primary Contact**

Name **Home Phone** **Cell Phone**

Employment **Work Phone**

Social Security No. **Driver's License No./ State** **Birth Date**

Person Financially Responsible (if other than parent) **Relationship to Child**

Dental Insurance Carrier (if any) **Whom may we thank for referring you**

DENTAL HISTORY

Date of last visit to dentist_____/_____/_____ For what service_____

1. Has child complained about dental problems ☐ Yes ☐ No _____
2. Any unhappy dental experiences ☐ Yes ☐ No _____
3. Any injuries to mouth-teeth-head ☐ Yes ☐ No _____
4. Any mouth habits (circle any that apply): thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier, other_____
5. Any unusual speech habits ☐ Yes ☐ No _____
6. Any lost teeth ☐ Yes ☐ No **7. Have missing teeth been replaced ☐ Yes ☐ No**
8. Orthodontic appliances ever been worn ☐ Yes ☐ No **9. Does child brush daily ☐ Yes ☐ No**
10. Use floss ☐ Yes ☐ No Frequency _____ **11. Use disclosing tablets ☐ Yes ☐ No**
12. Use fluoride ☐ Yes ☐ No In what form_____ Frequency _____
13. Child's attitude to dentistry_____

Piedmont Family Dentistry
181 W. WILKES MEDICAL CENTER RD.
FERGUSON, NC 28624
336-973-5060

HEALTH HISTORY

Child's physician_____ _____ _____
Address **Phone No.**

Date of last physical exam _____/_____/_____ **Results**_____

Is child currently under a physician's care ☐ **Yes** ☐ **No** **Reason**_____

Is child receiving medication or drugs ☐ **Yes** ☐ **No** **List, if any** _____

Is there any excessive bleeding when cut ☐ **Yes** ☐ **No**

Has child ever been hospitalized ☐ **Yes** ☐ **No** **Reason**_____

List any surgery child has ever had _____

Any allergy to penicillin or other drugs (specify)_____

Any other allergies (food-pollen-animals-dust-other)_____

Does child have good physical coordination ☐ **Yes** ☐ **No (specify)**_____

Does child have any emotional problems ☐ **Yes** ☐ **No (specify)**_____

_____

Does child have any history of or difficulty with any of the following:

☐ **Anemia**	☐ **Chronic sinus**	☐ **Hearing**	☐ **Mastoid**	☐ **Rheumatic Fever**
☐ **Asthma**	☐ **Convulsions**	☐ **Heart**	☐ **Measles**	☐ **Thyroid**
☐ **Bladder**	☐ **Diabetes**	☐ **Kidney**	☐ **Mononucleosis**	☐ **Tuberculosis**
☐ **Cerebral Palsy**	☐ **Epilepsy**	☐ **Liver**	☐ **Malignancies**	☐ **Venereal Disease**
☐ **Chicken Pox**	☐ **Fainting**	☐ **Mumps**	☐ **Other** _____	

_____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that has not been previously discussed

_____
_____
_____
_____
_____

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

_____ _____/_____/_____
Parent/Guardian Signature **Date_**