CHILD HEALTH HISTORY AND REGISTRATION FORM

M.W. MCCONNELL, D.D.S., INC.

Patient's Name:_____ Sex: M F Birthdate:_____ Age:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ Email Address:_____

How were you referred to us? Existing patient_____ Phone book Postcard Delta Superior Newspaper Internet/Website

Reason for your visit:_____

Name of Parent:_____ Person Responsible for Account:_____

Parent Employer:_____ Parent/Guardian Social Security#:_____

Parent Work Phone#:_____ Are you a full time student? Y N Mothers D.O.B._____ Fathers D.O.B._____

Emergency Contact (Name, address and phone number of someone not living in your home):_____

IT IS IMPORTANT THAT WE KNOW ABOUT YOUR MEDICAL AND DENTAL HISTORY. THESE FACTS HAVE A DIRECT BEARING ON YOUR DENTAL HEALTH AND TREATMENT. THIS INFORMATION IS STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE.

DENTAL HISTORY

Is this the child's first visit to a dentist? Y N

If no, how long since the child's last visit? Y N

Is the child having problems now? Y N

If so, explain_____

Is the child apprehensive about dental treatment? Y N

Have there been any injuries to the child's teeth? Y N

Are the child's teeth treated with fluoride at home/school? Y N

Has the child worn braces/orthodontics on his/her teeth? Y N

How many times a day does the child brush?_____

Circle if your child does one or more: Thumb sucking or Teeth Grinding

Other information you feel we should know_____

MEDICAL HISTORY

Have you (the child) ever had any of the following diseases or medical problems?

Heart Disease	Y N	Cancer/Chemo	Y N	Heart Murmur	Y N	Fever Blisters	Y N	Tuberculosis(TB)	Y N	HIV+/AIDS	Y N
Rheumatic Fever	Y N	Arthritis	Y N	Severe Headaches	Y N	Sickle Cell Disease	Y N	Heart Surgery	Y N	Hay fever	Y N
Chronic Hepatitis	Y N	Asthma	Y N	Anemia	Y N	Fainting Spells	Y N	Epilepsy/Seizures	Y N	High/Low B.P.	Y N
Psychiatric Treatment	Y N	Diabetes	Y N	Drug/Alcohol Abuse	Y N	Sinus Problems	Y N	Hemophilia/Abnormal Bleeding			Y N

PRIMARY DENTAL INSURANCE

Insured's Name:_____

Insured's Employer:_____

Social Security #:_____

Group #:_____

Insurance Phone #:_____

Insurance Company:_____

SECONDARY DENTAL INSURANCE

Insured's Name:_____

Insured's Employer:_____

Social Security #:_____

Group#:_____

Insurance Phone #:_____

Insurance Company:_____

BY SIGNING BELOW I AUTHORIZE THAT THE INFORMATION ON THIS SHEET IS TRUTHFUL AND ACCURATE TO THE BEST OF MY ABILITY AND KNOWLEDGE

PATIENT SIGNATURE: DATE: PHYSICIAN SIGNATURE:_____ DATE:_____