DEDHAM FAMILY DENTAL CHILD REGISTRATION/HISTORY

Child's Name:	Nickname:	Age:		D.O.B
Physician:	Physician's Phone #			
Person Responsible for this account:				
Address:	Phone #			
City: State:	Zip:			
Employed by:	Business #			
Business Address:				
Dental Insurance Plan:				
Group policy #	Individual policy #_			_
DENTAL HISTORY				
Dental Concerns:				
Date of last exam:				
Any previous unfavorable dental experience	ces?	Yes	No	
Grinds Teeth		Yes	No	
Fluoridated water		Yes	No	
Thumbsucking or other oral habits Frequency of brushing		Yes	No	
Rheumatic fever or heart murmur Asthma Heart Ailments Diabetes Hepatitis Emotional problems Seizures or epilepsy Bleeding disorders Kidney, liver, thyroid problems Cancer, leukemia, radiation or chem AIDS or HIV positive Sinus problems, hayfever	notherapy			
What medications does the child take? Any allergies to medications				
Any medical problems not listed above				
Sign	Date			
Parent or Guardian				
Sign	Date		_	
Provider				