Marc F. Lipkin, D.M.D.

Indian Valley Dental Assoc.
601 E. Broad St., Suite 200
Souderton, PA 18964
215-723-5531
www.indianvalleydental.com

CHILD'S REGISTRATION AND HISTORY

Date______________________________

Last name________________First name_________________Nickname_______________

Date of Birth___________

Address____Phone____________

School____Grade______________________

Father's Name____

Father Address (if different than above)____

Home Phone____________Work/Cell Phone______________Social Security #____________________

Father Employed by____

Fathers Employers Address____Phone #______________

Mother's Name____

Mother's Address (if different than above)____

Home Phone____________Work/Cell Phone______________Social Security #____________________

Mother Employed by____

Mothers Employers Address____Phone#_______________

Person Financially Responsible (if other than parent)________________________________

Whom may we thank for referring you____

What is child's favorite sport______________toy______________hobby__________________

DENTAL HISTORY

Previous Dentist______________________

Date of last dental visit________________

Has child complained about dental problems?.......Yes/No

Any unhappy dental experiences?................Yes/No

Please explain:_____________________________

Patient's attitude toward dentistry___________

Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc?..............Yes/ No

If yes, which habits?___________________

Any lost teeth?...........Yes/No

If so, which ones?_________________

Have missing teeth been replaced?.........Yes /No

Does your child brush teeth twice daily?........Yes /No

Do you assist child with brushing?.......Yes /No

Is dental floss used?.........Yes /No

Are disclosing tablets used?........Yes /No

Is fluoride taken in any form?........Yes /No

Any unusual speech habits?...........Yes/No

Are orthodontic appliances worn now or in the past?.......................Yes/No

If so, Orthodontists' Name____________________

Orthodontist's Address_______________________

Any other dental concerns____

(Please see back)

HEALTH HISTORY

Child's Physician________________________________Address____

Phone(_____)____________________________ Date of last physical exam________________________________

Is child under care of physician now?............................ Yes /No

Please list what types of medication your child is taking, if any:____
*please include prescription, over the counter, fluoride & any herbal supplements

Does child have good physical coordination?..................Yes /No

Is there any excessive bleeding when cut?...................... Yes /No

Has the child ever been hospitalized?.............................Yes /No-- If so, for what?__________________________

Has the child ever had surgery?......................................Yes/ No--If so, what type?__________________________

Is there any allergy to penicillin/ other medications?......Yes/No--If so, which?__________________________

Are there any other allergies?.. Yes /No–If so, to what?__________________________

Are there any emotional problems?................................ Yes /No–If so, please explain__________________________

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

Anemia	Chronic Sinusitis	Hearing Loss	Measles	Tuberculosis
Asthma	Convulsions/Epilepsy	Heart Murmur	Mononucleosis	Jaundice
Bladder Infections	Diabetes	Kidney Disease	Mumps	HIV/AIDS
Cerebral Palsy	Liver Disease	Rheumatic Fever	Hepatitis	
Chicken Pox	Fainting	Malignancies	Thyroid Disease	

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information that Indian Valley Dental Associates should be aware of.

____

____

During the course of treatment, local anesthetic("novocaine") may have to be used to avoid pain. Possible side effects, while not expected, could include, but not be limited to: prolonged numbness, infection, difficulty opening, short periods of excitability, bleeding, muscle soreness, biting lip or tongue, or unknown allergic reactions.

Parent or Guardian Signature____Date__________________________

Relation to Child____