Indian Valley Dental Associates

601 E. Broad Street • Souderton, PA 18964
215-723-5531

ADOLESCENT REGISTRATION AND HISTORY

In an effort to treat your young adult properly, this medical history has been developed specifically for young adults, ages 13 to 18.

Date _____

Name (Last) _____ (First) _____ (Middle) _____ (Nickname) _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Sex _____ Home Phone _____ School _____ Grade _____

Father's Name _____ Date of Birth _____ Cell Phone _____ Social Security No. _____

Father's Address _____ (if different than above)

Father's Employer _____ Work Phone _____

Mother's Name _____ Date of Birth _____ Cell Phone _____ Social Security No. _____

Mother's Address _____ (if differertt than above)

Mother's Employer _____ Work Phone _____

Person Financially Responsible (if different than above) _____ Whom may we thank for referring you? _____

DENTAL HISTORY

Date of last dental visit? _____ Previous dentist? _____

Has child complained about dental problems? ☐ Yes ☐ No

Does your child brush teeth twice daily? ☐ Yes ☐ No

Is dental floss used? ☐ Yes ☐ No

Us fluoride used in any form? ☐ Yes ☐ No

Any unhappy dental experiences? ☐ Yes ☐ No

Child's attitude towards dentistry? _____

Any unusual speech habits? ☐ Yes ☐ No

If so, please explain: _____

Is your child under the care of an orthodontist? ☐ Yes ☐ No

If so, orthodontist's name: _____

Any other dental concerns? _____

_____

(Medical History on Reverse)

MEDICAL HISTORY

Physician's Name _____ Phone No. _____

Date of last physical exam _____ Is child under the care of physician now? _____

Pharmacy Name _____ Phone No. _____

Please list medications (include over the counter, prescriptions, fluoride, and any herbal supplements)

Does child have good physical coordination?	☐ Yes	☐ No	Is there excessive bleeding when cut?	☐ Yes	☐ No
Has child ever been hospitalized?	☐ Yes	☐ No	If so, for what? _____		
Has child ever has surgery?	☐ Yes	☐ No	If so, for what? _____		
Is there an allergy to medication?	☐ Yes	☐ No	If so, to which? _____		
Are there any other allergies?	☐ Yes	☐ No	If so, to what? _____		
Are there any emotional problems?	☐ Yes	☐ No	If so, please explain: _____		
Does child smoke or use tobacco?	☐ Yes	☐ No	Is premedication needed prior to dental visit?	☐ Yes	☐ No
Females: Pregnant?	☐ Yes	☐ No	Birth Control Used?	☐ Yes	☐ No

DOES CHILD HAVE ANY HISTORY OF THE FOLLOWING?

Anemia	☐ Yes	☐ No	Chronic Sinus	☐ Yes	☐ No	Hearing Loss	☐ Yes	☐ No
Measles	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No	Bladder Infections	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Chicken POX	☐ Yes	☐ No	Fainting	☐ Yes	☐ No
Malignancies	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No	Other: _____		

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, difficulity opening, short periods of excitability, bleeding, muscle soreness, biting lip or tongue, or unknown allergic reactions.

Parent of Guardian Signature: _____ Date _____