Indian Valley Dental Associates

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

CHILD REGISTRATION AND HISTORY

In an effort to treat your child properly, this medical history has been developed specifically for children ages 3 to 12.

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 different than above)

Mother's Employer Work Phone

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

Child's Favorite Sport Favorite Toy Favorite Hobby

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
Are disclosing tablets used?	❑ Yes	❑ No	Are orthodontic appliances worn?	❑ Yes	❑ No
Any unhappy dental experiences?	❑ Yes	❑ No	Child's attitude towards dentistry? _____		
Any unusual speech habits?	❑ Yes	❑ No	If so, please explain: _____		
Mouth habits? (thumbsucking. pacifier, etc)	❑ Yes	❑ No	Have any missing teeth been replaced?	❑ Yes	❑ No
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 _____