RF | RICHARDS FRANKEL DENTISTRY

*Dentistry designed for health and well being.*

## CHILD'S REGISTRATION

1. Date _____
2. Child's Name _____
3. Nickname _____
4. Age _____
5. Date of Birth _____
6. School _____
7. Grade _____
8. Residence Address _____
9. City/State/ZIP Code _____
10. Father's Name _____
    - Social Security Number _____
    - Employer _____
    - Home Phone _____
    - Business Phone _____
11. Mother's Name _____
    - Social Security Number _____
    - Mother's Employer _____
    - Home Phone _____
    - Business Phone _____
    - Email Address _____
12. Person Financially Responsible (If other than parent)
    - Relationship to Child _____
    - Address _____
    - City/State/Zip Code _____
    - Phone _____
    - Email Address _____
13. Do you have dental insurance coverage _____ Ⓨ Ⓝ
    - Name of Insured _____
    - Social Security Number _____
    - Date of Birth of Insured _____
    - Name of Insurance Company _____
    - Phone Number of Insurance Company _____
    - ID Number of Insured _____
    - Group Number of Insured _____
14. How did you hear about us _____
15. What is your child's favorite hobby _____
16. What is your child's favorite toy _____

## CHILD'S DENTAL HISTORY

17. Date of last visit to a dentist _____
    - What service _____
18. Has your child complained about pain in his or her mouth __ Ⓨ Ⓝ
    - If so, please explain _____
19. Any unhappy past dental experiences _____ Ⓨ Ⓝ
    - If so, please explain _____
20. Any injuries to mouth, teeth or head _____ Ⓨ Ⓝ
    - If so, please explain _____
21. Any mouth habits, such as thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____ Ⓨ Ⓝ
    - If so, please explain _____
22. Any unusual speech patterns _____ Ⓨ Ⓝ
    - If so, please explain _____
23. Any lost teeth _____ Ⓨ Ⓝ
24. Is the child under the care of an orthodontist _____ Ⓨ Ⓝ
25. Does your child brush teeth daily _____ Ⓨ Ⓝ
    - How often _____
    - Do you assist child with tooth brushing _____
26. Is dental floss used _____ Ⓨ Ⓝ
    - How often _____
27. Is fluoride take in any form _____ Ⓨ Ⓝ
28. Child's attitude toward dentistry _____

DOCTOR'S SUMMARY

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## CHILD'S HEALTH HISTORY

1. Child's Physician _____
   - Address _____
   - Phone _____
2. Date of last physical examination _____
   - Results _____
3. Is your child under care of physician now _____ Ⓨ Ⓝ
   - If so, please explain _____
   - Physician's Name _____
   - Physician's Phone Number: _____
4. Is your child receiving any medication or drugs _____ Ⓨ Ⓝ
   - If so, please explain _____
5. Is there any prolonged bleeding when cut _____ Ⓨ Ⓝ
6. Has your child ever been hospitalized _____ Ⓨ Ⓝ
   - If so, please explain _____
7. Has your child ever had surgery _____ Ⓨ Ⓝ
   - If so, please explain _____
8. Allergies to penicillin or other drugs _____ Ⓨ Ⓝ
9. Allergies food, pollen, animals, dust, etc. _____ Ⓨ Ⓝ
   - If so, please explain _____
10. Does your child have good physical coordination _____ Ⓨ Ⓝ
11. Are there any emotional or psychological problems _____ Ⓨ Ⓝ
    - If so, please explain _____
12. Has child any history of or difficult with any of the following
    - ADD/ADHD _____ Ⓨ Ⓝ
    - Asthma _____ Ⓨ Ⓝ
    - Cancer _____ Ⓨ Ⓝ
    - Cerebral Palsy _____ Ⓨ Ⓝ
    - Chicken Pox _____ Ⓨ Ⓝ
    - Chronic Ear Infections _____ Ⓨ Ⓝ
    - Chronic Sinus Inflammation _____ Ⓨ Ⓝ
    - Convulsions _____ Ⓨ Ⓝ
    - Diabetes _____ Ⓨ Ⓝ
    - Epilepsy _____ Ⓨ Ⓝ
    - Fainting _____ Ⓨ Ⓝ
    - Hearing Disorder _____ Ⓨ Ⓝ
    - Heart _____ Ⓨ Ⓝ
    - Kidney _____ Ⓨ Ⓝ
    - Liver _____ Ⓨ Ⓝ
    - Mastoiditis _____ Ⓨ Ⓝ
    - Measles _____ Ⓨ Ⓝ
    - Mononucleosis _____ Ⓨ Ⓝ
    - Mumps _____ Ⓨ Ⓝ
    - Rheumatic Fever _____ Ⓨ Ⓝ
    - Thyroid Problems _____ Ⓨ Ⓝ
    - Tuberculosis _____ Ⓨ Ⓝ
    - Other _____ Ⓨ Ⓝ
13. Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information the doctor should be aware of that has not been discussed. _____

| DOCTOR'S SUMMARY |
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