Montgomery Pediatric Dentistry
Murray Dock, D.D.S., M.S.D.

CHILD'S REGISTRATION AND HISTORY

DATE: _____

CHILD'S NAME: _____ (LAST, FIRST) NICKNAME: _____ AGE: _____ BIRTHDATE: _____

HOME ADDRESS: _____ (STREET, CITY, STATE, ZIP) HOME PHONE: _____

FATHER'S NAME: _____ (LAST, FIRST) MOTHER'S NAME _____ (LAST, FIRST)

FATHER'S ADDRESS: _____ (STREET, CITY, STATE, ZIP) MOTHER'S ADDRESS _____ (STREET, CITY, STATE, ZIP)

FATHER'S CELL PHONE: _____ MOTHER'S CELL PHONE: _____

FATHER'S SS# _____ DOB _____ MOTHER'S SS# _____ DOB _____

FATHER'S OCCUPATION: _____ MOTHER'S OCCUPATION: _____

EMPLOYER: _____ EMPLOYER: _____

BUSINESS PHONE: _____ BUSINESS PHONE: _____

NAME OF DENTAL INS. CO. _____ NAME OF DENTAL INS. CO. _____

PERSON RESPONSIBLE FOR THIS ACCOUNT: _____

CHILD'S INTERESTS OR HOBBIES: _____

SCHOOL: _____ GRADE: _____

NO. CHILDREN LIVING AT HOME: _____ NAMES, AGES: _____

PURPOSE OF THIS APPOINTMENT: _____

DATE OF LAST VISIT TO A DENTIST: _____ FOR WHAT REASON? _____

DOES CHILD CURRENTLY HAVE A DENTAL PROBLEM? ❑ YES ❑ NO

IF YES, EXPLAIN: _____

HAD CHILD HAD ANY UNHAPPY DENTAL VISITS? _____

HOW OFTEN ARE CHILD'S TEETH BRUSHED? _____ MY WHOM? _____

DOES CHILD USE DENTAL FLOSS? ❑ YES ❑ NO FLOURIDE TAKEN IN ANY FORM? ❑ YES ❑ NO

ANY PREVIOUS INJURIES TO TEETH, MOUTH, HEAD? _____

ANY MOUTH HABITS? (THUMB SUCKING, NAIL BITING, ETC.) _____

* *

NAME OF CHILD'S PHYSICIAN: _____ PHONE NO: _____

PHYSICIAN'S ADDRESS _____

DATE OF LAST VISIT: _____ FOR WHAT REASON: _____

HAS CHILD EVER HAD ANY DIFFICULTY OR HISTORY OF:

❑ ALLERGIES	❑ DIABETES	❑ HEPATITIS	❑ DEVELOPMENTAL DISABILITY
❑ ANEMIA	❑ EMOTIONAL PROBLEMS	❑ KIDNEY	❑ SEIZURES
❑ ASTHMA	❑ HEARING	❑ LEARNING DISABILITIES	❑ TUBERCULOSIS
❑ BLEEDING PROBLEMS	❑ HEART TROUBLE	❑ LIVER	❑ OTHER

IF ANY OF THE ABOVE ARE CHECKED, PLEASE EXPLAIN: _____

_____

IS CHILD PRESENTLY TAKING ANY MEDICATIONS? ❑ YES ❑ NO FOR WHAT? _____

_____

DOES YOUR CHILD HAVE ANY SPECIAL PROBLEM NOT LISTED ABOVE? _____

_____

WHO REFERRED YOU TO THIS OFFICE? _____

CONSENT FOR TREATMENT - I AUTHORIZE THE PERFORMANCE OF ANY NECESSARY DENTAL SERVICES RECOMMENDED BY THIS OFFICE FOR THE ABOVE NAMED PATIENT AND WILL BE RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT.

SIGNED _____ DATE _____ RELATIONSHIP TO CHILD _____