Child's Registration and History

Dr. Rita Tamulis-Shea, D.D.S., Ltd.
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Patient's Information

Name_____ D.O.B._____ Age_____

Preferred Name _____ Gender _____ Place of Birth_____

Address _____ City_____Zip_____

Primary Phone _____ Secondary Phone _____

Father/Guardian's Information

Name _____ D.O.B_____ Social Security # _____-_____-_____

Address _____ City_____ Zip_____

Primary Phone _____ Secondary Phone _____

Email _____

Employer's Name and Address _____

Employer's Phone _____

Mother/Guardian's Information

Name _____ D.O.B_____ Social Security # _____-_____-_____

Address _____ City_____ Zip_____

Primary Phone _____ Secondary Phone _____

Email _____

Employer's Name and Address _____

Employer's Phone _____

General Information

Preferred Phone Numbers for Appointment Confirmation _____

With whom does the patient live with? _____

Names and Ages of Brothers _____

Names and Ages of Sisters_____

Dental Insurance? Yes_____ No_____ Group Number _____

Person responsible for account if other than above _____

Address_____ Phone ( ) _____

Child's Physician_____

Address _____ Phone ( ) _____

Family Dentist _____ Phone ( ) _____

Whom may we thank for referring you to our office? Doctor_____ Parent_____ Patient_____ Dentist _____

Name and Address _____

Health History

A. Is your child in good health? Yes / No
B. Does your child have regular medical exams? Yes / No
C. Is your child up to date with immunizations? Yes / No
D. Is your child currently undergoing medical treatment? Yes / No
   If so, for what? _____
E. Is your child presently taking any medications? Yes / No
   If so, what are they and for what reason? _____
   _____
F. Has your child experienced unfavorable reaction to
G. medicine? Yes / No
   If so, what? _____

H. Has your child ever been hospitalized? Yes / No
   If so, why? _____
I. Is your child allergic to anything? Yes / No
   If so, what?_____
J. Has your child received any blood or blood products? Yes / No
   If so, why and what date _____
K. Is there any chance your teenager is pregnant? Yes / No
L. Does your child experience recurrent headaches? Yes / No
M. Does your child have any emotional, mental, or nervous
   disorders? Yes / No
   if yes, please explain _____

Does your child currently have or previously had any of the following?

_____ Abnormal Bleeding
_____ ADD/ADHD
_____ Anemia
_____ Asthma
_____ Autism
_____ Birth Defects
_____ Blood Disorder
_____ Brain Damage
_____ Cancer/Tumors
_____ Cerebral Palsy
_____ Chicken Pox
_____ Chronic Sinusitis
_____ Convulsions/Seizures
_____ Diabetes
_____ Epilepsy
_____ Fainting
_____ Frequent Earaches
_____ Hearing Disorders
_____ Heart Disease
_____ Heart Murmur
_____ Hemophilia
_____ Hepatitis
_____ Hyperactivity
_____ Kidney/Bladder Disease
_____ Liver Disease
_____ Mononucleosis
_____ Mumps
_____ Poor Coordination
_____ Respiratory Disease
_____ Rheumatic Fever
_____ Sickle Cell Disease/Trait
_____ Sight Disorders
_____ Tuberculosis
_____ AIDS or AIDS rel. symptoms
_____ Other _____
_____

_____ **NONE OF THE ABOVE**

Please Help Us Get to Know Your Child

Patient's School _____ Favorite Toy _____

Favorite Game/Sport _____ Favorite Hobby _____

Favorite Fictional Character _____

Describe your child's temperament _____

Any social or school difficulties? _____

Dental History

Please answer the following

Any injuries to the mouth or head? Yes/No

Any of the following mouth habits? Yes/No

___ *thumb sucking* ___ *finger sucking*

___ *nail biting* ___ *nursing/bottle habits*

___ *pacifier* ___ *lip sucking*

___*tongue sucking*

Any unusual speech habits? Yes/No

Please explain _____

Does child brush his/her teeth? Yes/No

Do you assist with tooth brushing? Yes/No

How often? _____

Is dental floss used? Yes/No

How often? _____

Are disclosing tablets used? Yes/No

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

What toothpaste is usually used?_____

Please check if your child has or had

___ cavities
___ toothache
___teeth sensitive to sweets
___ teeth sensitive to hot
___ teeth sensitive to cold
___ frequent mouth blisters
___ bleeding gums
___ teeth bumped
___ crooked teeth
___ discoloration of teeth
___ bad breath
___ food packing
___ mouth breathing
___ grinding of teeth
___ clicking or popping of jaw
___ swollen gums
___ other dental problems
_____
_____

Other Dental Information

1. Was your child bottle fed? Yes / No
2. Is this your child's first dental visit? Yes / No
   If no, when was their last visit? _____ *Where?* _____
3. Has your child had an unfavorable experience in a dental office? Yes/No
4. Do you consider your child generally high strung or nervous? Yes/No
5. Purpose of this appointment? _____
6. Do you have any of the following?
   ___ *well water* ___*city water* ___*bottle water* ___*bottle water with fluoride*
7. Filtration system?
   ___*charcoal* ___*other* ___*none*

Please let us know if there any information that you think might be of value to us in treating your child.

_____

_____

_____

Because your child is a minor, it is necessary that a signed permission slip is obtained from a parent or guardian before any and all necessary dental service can be started and accomplished by Dr. Rita Tamulis-Shea. Authorization is hereby granted as such. Furthermore, I will be responsible for any bill incurred to this child for dental treatment.

Date _____ Signature _____

Parent or Guardian