Patient Registration and Medical History

Welcome to Kidz-R-Kool Pediatric Dentistry. We would like to welcome you and your child to our dental office. Our primary goal is to make every visit fun & educational. Our practice is based on preventive dental care. We strive to teach good oral care that will enable your child to maintain a beautiful smile for a lifetime!

About Your Child:

Child's Name ____ Nickname _________________________

Date of Birth ____ □ Male □ Female

Home Address ____ Home Phone ______________________

City __________________________________ State ______________ Zip Code ___________________________

How did you hear about our office?

□ Friend _______________ □ Dr Referral □ Paper □ Yellow Pages □ Internet □ Other _________________

Parents/Legal Guardians Information:

MOTHER'S INFORMATION **EMAIL ADDRESS** ____

Name ________________________________ Date of Birth ________________ Marital Status _________________

Address ____ Social Security _________________

City, State, Zip ____ Employer ______________________

Home Phone _________________________ Cell Phone __________________ Work Phone ___________________

FATHER'S INFORMATION **EMAIL ADDRESS** ____

Name ________________________________ Date of Birth ________________ Marital Status __________________

Address ____ Social Security __________________

City, State, Zip ____ Employer ______________________

Home Phone _________________________ Cell Phone __________________ Work Phone ___________________

Emergency Information:

In case of an emergency whether neither parent nor legal guardian can be reached, please identify the following information for the next closest relative **NOT** living with the patient.

Name _______________________________ Relation ______________________ Phone _________________________

Address, City, St, Zip ____

CHILD'S NAME: ____ (med hx page 2)

MEDICAL HISTORY

Has your child ever had any of the following conditions?

YES	NO		YES	NO	
O	O	Anemia	O	O	Hearing Impairment (right, left, both)
O	O	Heart Condition	O	O	Sexually Transmitted Disease
O	O	Tetralogy of Fallot	O	O	Kidney Disease or Transplant
O	O	Rheumatic Fever or Scarlet Fever	O	O	Liver Disease or Transplant
O	O	Bruise or Bleeds Easily	O	O	Hepatitis or Jaundice, date(s)________________
O	O	Asthma or Lung Problems	O	O	Stomach/GI Disorder ________________________
O	O	Pneumonia, date(s) _______________________	O	O	Thyroid Discorder
O	O	Cancer Malignancy, Leukemia, or Lymphoma	O	O	Currently Pregnant
O	O	Diabetes (*NIDDM* or *IDDM* _______ /day)	O	O	Implanted Shunts, Pins, Screws, or Rods
O	O	Seizures, Epilepsy, or Convulsions	O	O	Physical or Emotional Abuse
O	O	Fainting Spells	O	O	Ear Infection/Otitis Media, date(s) _________________
O	O	User of Tobacco Products	O	O	Cleft Lip/Palate
O	O	Drug or Alcohol Abuse	O	O	Learning Disability
O	O	Emotional or Behavioral Problems	O	O	Handicaps or Disabilities _____________________
O	O	Diagnosed with ADD, ADHD, or Hyperactivity	O	O	Congenital Birth Defects/Syndrome
O	O	Psychiatric Problems	O	O	Tuberculosis or Previous Positive Test
O	O	Seasonal Allergies, Hay Fever, etc	O	O	Delayed Development (Approx Age Function _______)

Is your child current on all age appropriate vaccines? O yes O no

Is your child currently taking any medication(s)? O yes O no If so, please list _____________________________

Is your child currently under the care of a physician? O yes O no If so, for what__________________________

Is your child allergic or has ever had an adverse reaction to a specific medication? O yes O no

if so, which medication(s) ____

PLEASE LIST THE NAMES & PHONE NUMBERS OF ANY TREATING PHYSICIANS

Type of Physician	Doctor's Name	Office Phone Number
Pediatrician		

DENTAL HISTORY

Has your child ever suffered from any of the following problems?

YES	NO		YES	NO	
O	O	Bad Breath/Halitosis	O	O	Popping or Soreness of Jaws (right, left, both)
O	O	Bleeding Gums	O	O	Dental Infection or Abscess
O	O	Stained or Discolored Teeth	O	O	Pain from Teeth
O	O	Cold Sores or Fever Blisters	O	O	Missing or Extra Teeth
O	O	Dry Mouth	O	O	Injury or Trauma to Teeth, Mouth, or Face

If so, Please explain __________________________

Has your child expressed any dental anxiety? O Yes O No

Does your child receive fluoride supplementation? O Yes O No

Does your child brush his/her teeth daily? O Yes O No If so, do you assist? O Yes O No

Does your child suck a thumb, finger, or pacifier? O Yes O No

How would you predict your child's behavior to be? O Cooperative O Fearful O Defiant O Don't know

How would you describe your child's current oral health? O Excellent O Good O Fair O Poor

What are you primary concerns about your child's oral health? ____

______________________________ ______________________________ ____________________

PARENT NAME (print) PARENT SIGNATURE DATE