Lakeshore Family
Dental Care, S.C.

CHILD'S REGISTRATION AND HISTORY

Child's Name: _____ ____/____/____
First Middle Last Date of Birth

Residence Address: _____
Street City, ST, ZIP

Parent(s) residing at this address: _____

If another party is financially responsible, please provide name and address:

_____

Dental Insurance:_____Employer:_____

DENTAL HISTORY

Reason for today's visit: _____

Date of last visit to dentist: ____/____/____ What was done at that visit? _____

Any unhappy dental experiences? _____

Any injuries to the mouth, teeth, or head? _____

Any mouth habits (e.g., thumbsucking)? _____

Any unusual speech patterns? _____

Orthodontic appliances worn or recommended? _____

Does this child brush daily? Y N With assistance? Y N How often? _____

Does this child use: Floss? Y N Disclosing solution? Y N Fluoride supplements? Y N

What would you like us to know about this child's attitude towards dentistry?

_____

MEDICAL HISTORY

Child's Physician: _____ Phone: _____ Date last visit: ____/____/____

Purpose of last visit: _____ May we contact Physician? Y N

Is child receiving any medicines/drugs? If yes, please list: _____

Is child allergic to any medication/drugs? Y N If yes, please list: _____

Does child have any medical condition that requires prophylactic antibiotics before dental visits? Y N

Any other medical related information that you would like us to know: _____

_____

Information given by: _____ Date: ____/____/____

Relationship to child: _____