Lakeshore Family Dental Care, S.C.

CHILD'S REGISTRATION AND HISTORY

First Middle Last Date of Birth Residence Address:	Residence Address:	
Street City, ST, ZIP Parent(s) residing at this address:	Street Parent(s) residing at this address:	
Parent(s) residing at this address: If another party is financially responsible, please provide name and address: If another party is financially responsible, please provide name and address: Dental Insurance:	Parent(s) residing at this address:	City ST 7IP
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 mouth habits (e.g., thumbsucking)?Any unusual speech patterns?Any with assistance? Y N How often?Any unusual speech patterns? Y N Usclosing solution? Y N Fluoride supplements? Y N What would you like us to know about this child's attitude towards dentistry?	If another party is financially responsible, please provide name and address: Dental Insurance:Employer:	• • •
Dental Insurance: Employer: DENTAL HISTORY Reason for today's visit:	Dental Insurance:Employer:	
DENTAL HISTORY Reason for today's visit:		
Reason for today's visit:	DENTAL HISTORY	
Date of last visit to dentist: /_/ What was done at that visit? Any unhappy dental experiences?		
Any unhappy dental experiences?	Reason for today's visit:	
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:	Date of last visit to dentist:/ / What was done at that visit?	
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:	Any unhappy dental experiences?	
Any unusual speech patterns?	Any injuries to the mouth, teeth, or head?	
Orthodontic appliances worn or recommended?	Any mouth habits (e.g., thumbsucking)?	
Does this child brush daily? Y N With assistance? Y N How often?	Any unusual speech patterns?	
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?	Orthodontic appliances worn or recommended?	
What would you like us to know about this child's attitude towards dentistry? MEDICAL HISTORY Child's Physician: Phone:	Does this child brush daily? Y N With assistance? Y N How	often?
MEDICAL HISTORY Child's Physician:	Does this child use: Floss? Y N Disclosing solution? Y N Flu	oride supplements? Y N
Child's Physician:	What would you like us to know about this child's attitude towards dentistry?	
Purpose of last visit:	MEDICAL HISTORY	
Is child receiving any medication/drugs? If yes, please list:	Child's Physician:Phone:	Date last visit://
Is child allergic to any medication/drugs? Y N If yes, please list:	Purpose of last visit: May	we contact Physician? Y N
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:	Is child receiving any medicines/drugs? If yes, please list:	
Any other medical related information that you would like us to know:	Is child allergic to any medication/drugs? Y N If yes, please list:	
Information given by: Date:/	Does child have any medical condition that requires prophylactic antibiotics be	fore dental visits? Y N
	Information given by:	Date: / /
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