CHILD'S REGISTRATION FORM

Child's Name _____ Nickname _____ Age_____

Date of Birth _____ Today's Date _____ Child's Physician_____

Name of School Attending _____

	Yes	No
Is child sensitive or allergic to anything?	☐	☐
Has child experienced any unfavorable reaction from any previous dental or medical care?	☐	☐
Has child lived or been living in an area where water supply was fluoridated?	☐	☐
History of heart trouble, rheumatic fever, epilepsy, diabetes, tuberculosis, bleeding, or mental disorders? If yes, underline	☐	☐
Does child have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
Has child ever taken Fen-Phen/Redux?	☐	☐
Is child in good health?	☐	☐
Please use reverse side for any additional information regarding child's history.		
Insurance _____	☐	☐

PERSON RESPONSIBLE FOR CHILD'S ACCOUNT

Ms.
Mrs.
Mr. _____

Single ☐ Married ☐ Divorced ☐ Widow ☐ Widower ☐

Residence address _____ Phone _____

E-Mail _____ Cell Phone _____

Business address _____ Phone _____

Present position _____

Referred by _____

SS#/SIN _____ Signature _____

ITEM 07-0566943/3371