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DR. SUPERTOOTH

STEPHEN J. HOWARD, D.D.S.

DENTISTRY FOR CHILDREN AND YOUNG ADULTS

REGISTRATION AND HEALTH HISTORY

Please complete this form in its entirety. Thank You.

_____
DATE

NAME _____ NICKNAME _____ AGE ____ DATE OF BIRTH ____/____/____

HOME ADDRESS _____ CITY _____ ZIP _____ PHONE _____

FATHER'S NAME _____ MOTHER'S NAME _____

FATHER'S ADDRESS _____ CITY _____ ZIP _____ CELL # _____
(if different from above)

MOTHER'S ADDRESS _____ CITY _____ ZIP _____ CELL # _____
(if different from above)

NAME OF NEAREST RELATIVE NOT LIVING WITH CHILD _____ PHONE _____

FATHER EMPLOYED BY _____ HOW LONG _____ PHONE _____

BUSINESS ADDRESS _____

MOTHER EMPLOYED BY _____ HOW LONG _____ PHONE _____

BUSINESS ADDRESS _____

PERSON FINANCIALLY RESPONSIBLE _____ RELATION TO CHILD _____

ADDRESS _____ CITY _____ ZIP _____ PHONE _____

SOCIAL SECURITY NUMBERS: FATHER _____ MOTHER _____

FATHER'S DATE OF BIRTH ____/____/____ MOTHER'S DATE OF BIRTH ____/____/____

WHEN DENTAL INSURANCE;
FATHER'S CARRIER _____ POLICY NUMBER _____

MOTHER'S CARRIER _____ POLICY NUMBER _____

PATIENT'S PERSONAL HISTORY

SIBLINGS: NAME'S _____ AGE'S _____

SCHOOL _____ GRADE ____ TEACHER _____

FAVORITE HOBBY, SPORT, INTERESTS _____

LIST SEVERAL FRIENDS _____

_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PATIENT'S DENTAL HEALTH

DATE OF LAST DENTAL VISIT _____

NAME OF DENTIST _____

FOR WHAT SERVICE _____

AGE WHEN FIRST TOOTH ERUPTED _____

	YES	NO
HAS CHILD COMPLAINED ABOUT DENTAL PROBLEMS	☐	☐
ANY UNHAPPY DENTAL EXPERIENCES	☐	☐
ANY INJURIES TO MOUTH-HEAD-TEETH	☐	☐
MOUTH BREATHER	☐	☐
THUMB OR FINGER SUCKER	☐	☐
ANY UNUSUAL HABITS	☐	☐
ANY OTHER ORAL HABITS	☐	☐
	☐	☐

	YES	NO
DOES YOUR CHILD BRUSH TEETH DAILY	☐	☐
DO YOU ASSIST CHILD WITH BRUSHING	☐	☐
IS DENTAL FLOSS USED	☐	☐
IS FLOURIDE TAKEN IN ANY FORM	☐	☐

CHILD'S ATTITUDE TO DENTISTRY _____

DOES MOTHER HAVE A HISTORY OF DENTAL PROBLEMS	☐	☐
DOES FATHER HAVE A HISTORY OF DENTAL PROBLEMS	☐	☐
DO YOU DESIRE COMPLETE DENTAL SERVICE	☐	☐

(REV. 03/11)

WHAT IS CHILD'S CURRENT DIET:

FAVORITE LIQUID FOOD: _____ FAVORITE SOLID FOOD _____

AVERAGE DAILY BREAKFAST: _____

USUAL DINNER BEVERAGE: _____

PATIENT'S HEALTH HISTORY

CHILD'S PHYSICIAN _____ ADDRESS _____ PHONE _____

DATE OF LAST PHYSICAL EXAMINATION _____ RESULTS _____

	YES	NO		YES	NO
IS CHILD UNDER CARE OF PHYSICIAN NOW	☐	☐	IS THERE ANY ALLERGY TO PENICILLIN OR OTHER DRUGS	☐	☐
IS CHILD RECEIVING ANY MEDICATION OR DRUGS	☐	☐	ARE THERE OTHER ALLERGIES: FOOD-POLLEN	☐	☐
IS THERE ANY EXCESSIVE BLEEDING WHEN CUT	☐	☐	DOES CHILD HAVE GOOD PHYSICAL COORDINATION	☐	☐
HAS CHILD EVER BEEN HOSPITALIZED	☐	☐	ARE THERE ANY EMOTIONAL PROBLEMS	☐	☐
HAS CHILD EVER HAD SURGERY	☐	☐	SUMMARY _____		

_____

HAS CHILD HAD ANY HISTORY OF THE FOLLOWING:

ANEMIA _____	CHICKEN POX _____	DIARRHEA _____	HEARING _____	MUMPS _____
ASTHMA _____	CONGESTION (SEASONAL) _____	EPILEPSY _____	HEART _____	NIGHT WALKING _____
BED WETTING _____	CONGESTION (NONSEASONAL) _____	FAINTING _____	KIDNEY _____	RHEUMATIC FEVER _____
BLADDER _____	CONVULSIONS _____	FREQUENT _____	LIVER _____	THYROID _____
CEREBRAL PALSY _____	DIABETES _____	CONSTIPATION _____	MALIGNANCIES _____	OTHER _____
		GASTRITIS _____	MEASLES _____	

SUMMARY (For Doctor's Use) _____

_____

_____

_____

_____

_____

_____

I authorize Dr. Howard to use my child's photo for display purposes only.

Signature of Parent or Guardian _____ Date ____/____/____

I authorize Dr. Howard to perform all recommended treatment mutually agreed upon by me.

Signature of Parent or Guardian _____ Date ____/____/____

I understand that it is my responsibility to pay for dental services provided in this office for today's treatment and all future treatments. Payment is due and payable at the time services are rendered unless other arrangements have been made. If dental insurance is in force I will pay my co-payment at the time services are rendered.

Signature of Parent or Guardian _____ Date ____/____/____