Dr. Rebecca A. Faunce D.M.D.

Child's Registration and History

Child's name________________________________Nickname______________________

Age_________Birth date________________School____________________Grade_______

Favorite: Hobby____________Sport______________Toy__________Person____________

Father's name_________________________Birth date__________SS#_______________

Address_________________________City_______________State________Zip__________

Home phone________________Work phone____________________Cell______________

Employed by________________________________How long______________________

Mother's name_________________________Birth date__________SS#_______________

Address_________________________City_______________State________Zip__________

Home phone________________Work phone____________________Cell______________

Employed by________________________________How long______________________

Whom may we thank for referring you ____

Dental Insurance

Primary subscriber's name_________________________________DOB_______________

SS#________________Insurance company____

Group#__________________ID#______________________Phone___________________

Secondary Subscriber's name______________________________DOB_______________

SS#________________Insurance company____

Group#__________________ID#______________________Phone___________________

Child's Dental History

Dentist name________________________________Phone______________________

Last dental visit_________________________For what service______________________

YES NO

□ □ Complaints of dental problems. If yes explain______________________________

□ □ Any unhappy experiences. If yes explain__________________________________

□ □ Any injuries to: Mouth-Teeth-Head. If yes explain___________________________

□ □ Any mouth habits: Thumb sucking-Nail biting-Mouth breathing-Nursing bottle habits-Pacifier-ect. If yes explain____

□ □ Any unusual speech habits. If yes explain_________________________________

□ □ Any lost teeth. If yes explain____

□ □ Have missing teeth been replaced. If yes explain___________________________

□ □ Does your child brush teeth daily_______________________________________

□ □ Do you assist child with brushing. If yes how often__________________________

□ □ Is dental floss used. If yes how often____________________________________

□ □ Are disclosing tablets used____

□ □ Is Fluoride taken in any form____

□ □ Do you desire assistance in finding dental services for your child_______________

□ □ Orthodontic appliances worn now or ever been worn ________________________

□ □ Any family member that is in or has had orthodontic treatment with our office. If yes which office and name of family member/s ___________________________________

____

Child's attitude to dentistry____

Child's Health History

Physician's name_______________________________________Phone_____________________

Date of last physical examination________________________Results_____________________

YES NO

□ □ Is child under care of a physician now____

□ □ Is child receiving any medication or drugs. If yes explain ____________________

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□ □ Is there any excessive bleeding when cut____

□ □ Has child ever been hospitalized. If yes explain_________________________________

□ □ Has child ever had surgery. If yes explain ______________________________________

□ □ Allergies to any drugs. If yes explain____

□ □ Allergies to any: Food-Pollen-Animals-Latex-Other ____________________________

□ □ Does child have good physical coordination ______________________________________

□ □ Are there any emotional problems ____

Has child any history of or difficulty with any of the following:

_______Anemia	_______Asthma	_______Bladder
_______Cerebral Palsy	_______Chicken Pox	_______Chronic Sinus
_______Convulsions	_______Diabetes	_______Epilepsy
_______Fainting	_______Hearing	_______Heart
_______Kidney	_______Liver	_______Malignancies
_______Mastoid	_______Measles	_______Mononucleosis
_______Mumps	_______Rheumatic Fever	_______Thyroid
_______Tuberculosis	_______Venereal Disease	_______Other

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

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YES NO

□ □ May we request release of your child's medical records_______________________

Summary:
(for doctor's use)

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Parent or Guardian Signature____

Relation to child____

201 Health Park Blvd. Suite 216 St. Augustine Florida 32086 Phone (904) 829-8899