Welcome

GERALD R. RYAN, D.D.S.

CHILD'S REGISTRATION AND HEALTH HISTORY

Today's Date _____

Child's Name _____ Nickname _____ Birthdate _____

Address: _____ City _____ Zip _____

Male ❑ Female ❑ Age _____ School _____ Grade _____

Father's Name _____ Soc. Secur. # _____

Mother's Name _____ Soc. Secur. # _____

Sister's Names and Ages _____

Brothers' Names and Ages _____

Father Employed By _____ Home Phone _____ Bus. Phone _____

Mother Employed By _____ Home Phone _____ Bus. Phone _____

Child's Physician: _____ Address _____ Phone _____

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES? **YES** ❑ **NO** ❑

WHOM MAY WE THANK FOR REFERRING YOU? _____

MEDICAL HISTORY

	YES	NO
1. Is your child being treated for any condition by a physician now?	❑	❑
2. Is child taking any medicines now? If **YES**, please list:	❑	❑
3. Has child ever been hospitalized or had major surgery?	❑	❑
4. Is there any allergy to penicillin or other drugs?	❑	❑
5. Are there any emotional or mental problems?	❑	❑

6. Has your child ever had any of the following?

	YES	NO
Heart Murmur	❑	❑
Rheumatic Fever	❑	❑
Arthritis	❑	❑
Hepatitis (yellow skin and eyes)	❑	❑
Diabetes (sugar disease)	❑	❑
High Blood Pressure	❑	❑
Tuberculosis	❑	❑
Asthma	❑	❑
AIDS	❑	❑
Chicken Pox	❑	❑
Measles	❑	❑
Convulsions	❑	❑
Cerebral Palsy	❑	❑

(Continued on Back)

DENTAL HISTORY

Is this the child's first visit to the dentist? _____ If no, at what age was first visit? _____ Last visit? _____

Who brushes child's teeth? _____ When are child's teeth usually brushed? _____

For how long? _____ Is dental floss used? _____

	YES	NO
Is your child worried about receiving dental treatment?	❑	❑
Are you dissatisfied with the appearance of your child's teeth?	❑	❑
Does child frequently snack between meals ..... on Sweets? _____ Starches? _____ Chewing Gum? _____ Soft Drinks? _____	❑	❑
Does child have any sensitive teeth?	❑	❑
Has child had a toothache recently?	❑	❑
Any bleeding gums?	❑	❑
Any frequent canker sores or cold sores?	❑	❑
Has child ever had orthodontic treatment (teeth straightened)?	❑	❑

	YES	NO
Any injuries to mouth, teeth, or head?	❑	❑
Any mouth habits: Thumb sucking, nail biting, mouth breathing, etc.?	❑	❑
Any unusual speech habits?	❑	❑
Has there been a previous unhappy dental experience?	❑	❑
Has child had sealants or fluoride treatments to reduce the rate of new cavities?	❑	❑
Did either of child's parents lose all their teeth?	❑	❑
Are you satisfied with your child's past dentistry?	❑	❑

Parent's Signature Date

NOTES