Hendricks Family Dentistry, Inc.
4181 Center Road
Brunswick, OH 44212
Phone 330-225-1433

CHILD'S REGISTRATION

Date_____

Child's Name_____ Nickname_____ Age_____ Birthdate_____

Residence Address_____ City_____ State_____ Zip_____

School_____ Grade_____

Father's name_____ Mother's name _____

Father employed by_____ Bus. #_____ Home #_____

Cell #_____ E-mail address_____

Mother employed by_____ Bus. #_____ Home#_____

Cell #_____ E-mail address_____

Person financially responsible (if other than custodial parent)_____ Relationship to child_____

Address_____ City_____ State_____ Zip_____

Father's Social Security Number_____ Mother's Social Security Number_____

Father's birthdate_____ Mother's birthdate_____

Name of Dental Insurance Carrier _____ Secondary Insurance coverage, if any_____

Whom may we thank for referring you?_____ Child's interests:_____

DENTAL HISTORY

Date of last visit to a dentist _____
For what service?_____
_____

	YES	NO
Has child complained about dental problems?	❑	❑
Any unhappy dental experiences?	❑	❑
Any injuries to mouth —teeth—head?	❑	❑
Any mouth habits—thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.?	❑	❑
Any unusual speech habits?	❑	❑
Any lost teeth?	❑	❑
Have missing teeth been replaced?	❑	❑
Orthodontic appliances worn now or previously?	❑	❑

	YES	NO
Does your child brush teeth daily?	❑	❑
Do you assist child with tooth brushing? How often?	❑	❑
Is dental floss used? How often?	❑	❑
Is fluoride taken in any form?	❑	❑
Do you desire complete dental service for the child?	❑	❑

Child's attitude to dentistry_____

Summary (for doctor's use)_____