



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 _____						YES NO
For what service? _____				Does your child brush teeth daily? _____	<input type="checkbox"/>	<input type="checkbox"/>
_____				Do you assist child with tooth brushing? _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	YES	NO		How often? _____		
Has child complained about dental problems? _____	<input type="checkbox"/>	<input type="checkbox"/>		Is dental floss used? _____	<input type="checkbox"/>	<input type="checkbox"/>
_____				How often? _____		
Any unhappy dental experiences? _____	<input type="checkbox"/>	<input type="checkbox"/>		Is fluoride taken in any form? _____	<input type="checkbox"/>	<input type="checkbox"/>
_____				Do you desire complete dental service for the child? _____	<input type="checkbox"/>	<input type="checkbox"/>
Any injuries to mouth —teeth—head? _____	<input type="checkbox"/>	<input type="checkbox"/>		Child's attitude to dentistry _____		
_____				_____		
Any unusual speech habits? _____	<input type="checkbox"/>	<input type="checkbox"/>		_____		
_____				Summary (for doctor's use) _____		
Any lost teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>		_____		
_____				_____		
Have missing teeth been replaced? _____	<input type="checkbox"/>	<input type="checkbox"/>		_____		
_____				_____		
Orthodontic appliances worn now or previously? _____	<input type="checkbox"/>	<input type="checkbox"/>		_____		
_____				_____		