Sconzo & Sconzo, D.M.D., P.C.
1666 Marine Parkway - Brooklyn, NY 11234
718-339-0252

Child's Registration and History

Child's Name (First, Last) _____ _____
Date
Nickname_____ **Age**_____ **D.O.B.**_____
Address_____ **City**_____ **State**_____ **Zip**_____
School_____ **Address**_____ **Grade**_____
Father's Name_____ **Mother's Name**_____

Father's Employment_____ **How Long**_____
Home Phone_____ **Business Phone**_____
Father's SS#_____ **D.O.B.**_____
EMAIL:_____

Mother's Employment_____ **How Long**_____
Home Phone_____ **Business Phone**_____
Mother's SS#_____ **D.O.B.**_____
EMAIL:_____

Person Financially Responsible (If other than parent)_____
Relationship to Child_____
Address_____ **Phone**_____

Do you have dental insurance? _____ **If so, which one?** _____
Secondary Insurance? (If any)_____

Whom may we thank for referring you? _____

What is your child's favorite toy? _____
What is your child's favorite hobby? _____
What is your child's favorite fictional character or person? _____

Dental History

Does your child brush his/her teeth daily?_____
Do you assist child in brushing teeth?_____ **How Often?**_____
Is dental floss used?_____ **How Often?**_____
Are disclosing tablets used?_____ **Is fluoride taken in any form?**_____
Do you desire complete dental service for the child?_____
Child's attitude towards dentistry?_____
Summary (for doctor's use)_____
_____
_____

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Date of last visit to a dentist_____
For what service? _____
Has child complained about dental problems? _____
Any unhappy dental experiences? _____
Any injuries to mouth-teeth-head? _____
Any mouth habits-thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc….. _____
Any unusual speech habits?_____
Any teeth lost?_____
Have any missing teeth been replaced? _____
Orthodontic appliances worn now or ever been? _____

Health History

Child's Physician _____ Phone #_____
Address _____
Date of last physical examination_____ Results_____
Is child under care of physician now?_____
Is child receiving any medication or drugs?_____
Is there any excessive bleeding when cut? _____
Has child ever been hospitalized? _____
Has child ever had surgery?_____
Is there any allergic to penicillin or other drugs? _____
Are there any other allergies: food-pollen-animals-dust-other? _____
_____

Does your child have good physical coordination? _____
Are there any emotional problems? _____

Summary (For doctors use) _____
_____
_____

Has child any history of or difficulty with any of the following. Please circle if any.

-Anemia	**-Chronic sinus**	**-Hearing**	**-Mastoid**	**-Thyroid**
-Asthma	**-Convulsions**	**-Heart**	**-Measles**	**-Tuberculosis**
-Bladder	**-Diabetes**	**-Kidney**	**-Mononucleosis**	**-Venereal disease**
-Cerebral Palsy	**-Epilepsy**	**-Liver**	**-Mumps**	**-Other**
-Chicken Pox		**-Fainting**	**-Malignancies**	**-Rheumatic Fever**

Summary (for doctor's use)_____
_____
_____

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

_____

_____

May we request release of your child's medical records for our reference?__ _____
This information was discussed with and given by _____
Relationship to Child _____