FRANTAL DENTAL CARE
7601 PERSHING BLVD #1
KENOSHA, WI 53142
(262) 694-1100

CHILDREN'S REGISTRATION & MEDICAL HISTORY

CHILD'S NAME [First, Middle Initial, Last] ____ PREFERRED NAME_____________

DATE OF BIRTH___________ADDRESS_______________________________CITY/STATE/ZIP__________________________

FATHER'S NAME___________________ADDRESS______________________________CITY/STATE/ZIP______________________

SOCIAL SECURITY #_________________EMPLOYER_______________DENTAL INS___________________GROUP #_________

HOME PHONE_______________________WORK PHONE____________________ BIRTH DATE_________________

MOTHER'S NAME____________________ADDRESS__________________________CITY/STATE/ZIP_________________________

SOCIAL SECURITY #_________________EMPLOYER_________________DENTIAL INS___________________GROUP #_______

HOME PHONE_______________________WORK PHONE_____________________BIRTH DATE__________________

WHOM MAY WE THANK FOR REFERRING YOU? ____

WHY DID YOU BRING YOUR CHILD TO DENTIST TODAY? ____

HAS CHILD EVER HAD A SERIOUS/ DIFFICULT PROBLEM ASSOCIATED WITH PREVIOUS DENTAL WORK? YES/NO

IS CHILD A MOUTH BREATHER OR SNORER? YES/NO IS CHILD TAKING FLUORIDATED SUPPLEMENTS? YES/NO

IS THERE A FAMILY HISTORY OF ORTHODONTICS? YES/NO

IS THERE A FAMILY HISTORY OF CONGENITALLY MISSING TEETH? YES/NO

DOES THE CHILD BRUSH/FLOSS TEETH DAILY? YES/NO DO PARENTS HELP WITH BRUSHING/FLOSSING? YES/NO

DOES CHILD HAVE/HAD ANY OF THE FOLLOWING HABITS? [PLEASE CIRCLE IF YES]

PACIFIER HABIT/ PAST 1 YEAR OLD BOTTLE HABIT/ PAST 1 YEAR OLD

THUMB/FINGER/LIP SUCKING OR BITING NAIL BITING

CHILD'S PEDIATRICIAN /PHYICIAN ________________________________HEALTH: _____GOOD_____ FAIR _____ POOR

IS CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN? YES/NO

PLEASE EXPLAIN: ____

HAS CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMES? [PLEASE CIRCLE IF YES]

RHEUMATIC FEVER	ASTHMA	TUBERCULOSIS	HEARING IMPAIRMENT
CONVULSION/EPILEPSY	CANCER	HEMOPHILIA	CONGENITAL HEART DEFECT
ABNORMAL BLEEDING	DIABETES	HEPATITIS	KIDNEY/LIVER PROBLEMS
HEART MURMUR	HIV/AIDS		

BLOOD TRANSFUSIONS DATE: _______________________

ANY OPERATIONS OR HOSPITALIZATION? ____________________________________

ANY HANDICAPS OR DISABILITIES? ______________________

IS CHILD ALLERGIC TO ANY OF THE FOLLOWING DRUGS? [PLEASE CIRCLE IF YES]

PENICILLIN ASPIRIN ERYTHROMYCIN TETRACYCLINE CODEINE SULFA LATEX

DENTAL ANESTHETICS ANY OTHERS? ____

PLEASE EXPLAIN ANY SERIOUS MEDICAL PROBLEMS THE CHILD HAS HAD TO ANY MEDICINES, AND DOSAGES THE CHILD IS PRESENTLY TAKING. ____

BECAUSE YOUR CHILD IS A MINOR, IT BECOMES NECESSARY THAT SIGNED PERMISSION BE OBTAINED FROM A PARENT OR GUARDIAN BEFORE, DRS. TERRENCE K. OR MICHAEL P FRANTAL, PERFORMS ALL NECESSARY DENTAL TREATMENT. THE SIGNATURE OF THE PARENT OR GUARDIAN AFFIXED BELOW AUTHORIZES THE COMPLETION OF ALL AGREED UPON DENTAL TREATMENT AND THE USE OF NECESSARY METHODS APPROPRIATE IN DOING SO. THIS CONSENT SHALL REMAIN IN FULL FORCE AND EFFECT UNTIL CANCELLED BY EITHER PARTY. FURTHERMORE, I WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED FOR THIS CHILD'S DENTAL TREATMENT.

SIGNED____ **DATE** ___________________________

I VERBALLY REVIEWED THE MEDICAL/DENTAL INFORMATION ABOVE WITH PARENT/GUARDIAN FOR ABOVE NAMED PATIENT. **RDH/DDS**______________________

1. UPDATE ____________ SIGNED ______________________________
2. UPDATE ____________ SIGNED ______________________________
3. UPDATE ____________ SIGNED ______________________________
4. UPDATE ____________ SIGNED ______________________________
5. UPDATE ____________ SIGNED ______________________________
6. UPDATE ____________ SIGNED ______________________________