CANTON PROFESSIONAL PARK
8550 CANTON CENTER ROAD • CANTON, MICHIGAN 48187

CHILD HEALTH REGISTRATION

Name: _____ Phone: (H): _____

Address: _____ (W): _____

_____ (C): _____

Birthdate: _____

Father's Name: _____	Mother's Name: _____
Birthdate: _____	Birthdate: _____
Social Security #: _____	Social Security #: _____
Employed By: _____	Employed By: _____
Work Phone: _____	Work Phone: _____
Dental Insurance: _____	Dental Insurance: _____
Group Number: _____	Group Number: _____

Person Responsible for Account: _____

MEDICAL HISTORY

Physician's name: _____

Is your child taking any medication now? ..... For what purpose? _____ Yes ☐ No ☐

Has your child ever been treated for:

Rheumatic fever	Yes ☐	No ☐	Heart murmur	Yes ☐	No ☐
Abnormal blood pressure	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	HIV+/AIDS	Yes ☐	No ☐
Tuberculosis or lung disease	Yes ☐	No ☐	Sinus trouble/Asthma/Hay Fever	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Cough	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Congenital heart lesions	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
			Glaucoma	Yes ☐	No ☐

Have your child ever been treated (other than diagnostic) with x-ray? ..... Yes ☐ No ☐

Allergies: Latex ☐ Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other medications ☐

Is your child subject to prolonged bleeding? ..... Yes ☐ No ☐

Does your child have excessive urination and/or thirst? ..... Yes ☐ No ☐

DENTAL HEALTH

Reason for visit: _____

Is this your child's first visit to a dentist? _____ When was your child's last dental visit? _____

When was the last full set of x-rays taken? _____

Has your child ever had any serious problem associated with previous dental treatment? ..... Yes ☐ No ☐

If so, explain: _____

_____

How often does your child brush? _____ Type of brush used? Soft ☐ Medium ☐ Hard ☐ Nylon ☐ Natural ☐

Referred by: _____

Parent's Signature: _____ Date: _____