

(You **MUST** fill out the registration in order for your child to participate in this program)

**PREVENTATIVE DENTAL PROGRAM
REGISTRATION FORM**

Student's Name: _____

School: _____

Date of Birth: _____ Social Security #: _____ Grade: _____

Parent/Guardian's Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Emergency Contact: _____

Dental Insurance Carrier: _____

Member or MA#: _____ Group #: _____

The following medical/dental history questions must be answered if you wish for your child to participate in this valuable program:

HEALTH HISTORY: (Please circle yes or no).

| | | | | | |
|-----|----|----------------------|-----|----|---------------------|
| Yes | No | Asthma | Yes | No | Latex Allergies |
| Yes | No | Bleeding Problems | Yes | No | Rheumatic Fever |
| Yes | No | Epilepsy or Seizures | Yes | No | Sickle Cell Disease |
| Yes | No | Heart Murmur | Yes | No | Tuberculosis |
| Yes | No | Hepatitis | | | |

Known Allergies to Medicine (please list): _____

Additional health information we should know about your child: _____

DENTAL HISTORY: (Please circle yes or no).

Yes No Is your child currently complaining, or have they complained in the last six months of any mouth pain?

Yes No Has your child visited a dentist before?

Yes No Does your child routinely go for six-month check-ups?

Yes No Has your child ever had Dental Sealants?

Yes No Does your child take fluoride supplements or participate in the school fluoride program?

Yes No Does your child need to be pre-medicated prior to a dental visit?

Does your home have: _____ town water? _____ a well?

Who is your child's dentist? _____ Date of last Dental Cleaning _____

If you would like a report of your child's visit faxed to the dentist list above, please initial here _____