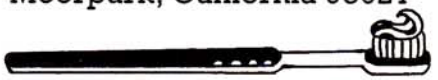
David Canale, DDS
165 E. High St., Suite 101
Moorpark, California 93021



CHILD REGISTRATION AND HEALTH HISTORY

Child's Name_____ Child's Age_____

Address_____

City_____State_____Zip_____

Home Phone_____ Child's Birth date _____

Mother's Name_____Parent's Marital Status ☐Married ☐Single ☐Divorced

Father's Name_____Referred By_____

Dental Insurance Carrier_____

Person Financially Responsible For Account_____

Address_____City_____State_____Zip_____

Work Phone_____Social Security #_____Birth date_____

Employed By_____Address_____

Primary Reason For This Visit_____

Please answer each question. Circle YES or NO

1. Is child under medical treatment now? Yes No
If yes please explain_____

2. Has Child had any operations? Yes No
If yes please list_____

3. Is Child allergic to penicillin, latex or any other drugs or medications? Yes No
If yes, please list _____

4. Is Child taking any drugs or medications? Yes No
If yes, please list_____

5. When cut, does child's bleeding stop within a normal period of time? Yes No

6. Does child have any other health problems which you wish to discuss with the Doctor? Yes No

7. Does child require antibiotics before dental treatment? Yes No

Has your child had any of the following?

Heart Ailment	Yes No	Nervous Disorder	Yes No	Kidney Disease	Yes No
High Blood Pressure	Yes No	Epilepsy	Yes No	Ulcer	Yes No
Cardiac Pacemaker	Yes No	History of Fainting	Yes No	Respiratory Disease	Yes No
Rheumatic Fever	Yes No	Tuberculosis	Yes No	Sinus Trouble	Yes No
Heart Murmur	Yes No	Hepatitis	Yes No	Serious Head Injury	Yes No
Blood disease or Anemia	Yes No	Tumors or Growths	Yes No		
Diabetes	Yes No	Liver Disease	Yes No	_____	Yes No

Is your child's health: ☐*Excellent* ☐*Good* ☐*Fair* ☐*Poor*

I confirm that the above information is true to the best of my knowledge and I consent to whatever dental procedures, including X-rays and local anesthetics that are deemed necessary for diagnosis and treatment.

Signature of parent or guardian_____ Date_____