JEFFERY S. WEBB, D.D.S.

CHILD'S REGISTRATION AND HISTORY

DATE _____

CHILD'S FULL NAME _____ NICK NAME _____ AGE _____ BIRTHDATE _____

RESIDENCE ADD. _____ HM. PHONE _____

_____ SCHOOL _____ GRADE _____

FATHER'S NAME _____ BIRTHDATE _____ S.S.# _____

FATHER'S EMPLOYER _____

BUS. ADD. _____ BUS. PHONE _____

MOTHER'S NAME _____ BIRTHDATE _____ S.S.# _____

MOTHER'S EMPLOYER _____

BUS. ADD. _____ BUS. PHONE _____

PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN PARENT) _____ RELATIONSHIP TO CHILD _____

MAILING ADD. _____ HM. PHONE _____ WK. _____

_____ DOES CHILD HAVE DENTAL INSURANCE COVERAGE? YES ___ NO ___

PERSON INSURED? MOTHER ___ FATHER ___ INS. CO. _____ GROUP# _____

OTHER PERSON INSURED? MOTHER ___ FATHER ___ INS. CO. _____ GROUP# _____

WHOM MAY WE THANK FOR REFERRING YOU _____

WHAT IS CHILD'S FAVORITE SPORT _____ FAVORITE TOY _____

FAVORITE HOBBY _____ FAVORITE PERSON _____ FAVORITE FICTION CHARACTER _____

DENTAL HISTORY

Date of last visit to a dentist _____

For what service _____

_____ YES ☐ NO ☐

Has child complained about dental problems _____

_____

Any unhappy dental experiences _____

_____

Any injuries to mouth - teeth - head _____

_____

Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____

_____

Any unusual speech habits _____

_____

Any lost teeth _____

_____

Have missing teeth been replaced _____

_____

Orthodontic appliances worn now or ever been _____

YES NO

Does your child brush teeth daily _____ ☐ ☐

Do you assist child with tooth brushing _____ ☐ ☐

How often _____

Is dental floss used _____ ☐ ☐

How often _____

Are disclosing tablets used _____ ☐ ☐

Is fluoride taken in any form _____ ☐ ☐

_____

Child's attitude to dentistry _____

_____

Do you desire complete dental service for the child _____ ☐ ☐

_____

_____

Summary (for doctor's use) _____

_____

_____

_____

_____

HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO		YES	NO
Is child under care of physician now _____	☐	☐	Does child have good physical coordination _____	☐	☐
Is child receiving any medication or drugs _____	☐	☐	Are there any emotional problems _____	☐	☐
Is there any excessive bleeding when cut _____	☐	☐	Summary (for doctor's use) _____		
Has child ever been hospitalized _____	☐	☐			
Has child ever had surgery _____	☐	☐			
Is there any allergy to penicillin or other drugs _____	☐	☐			
Are there other allergies: food - pollen - animals - dust - other	☐	☐			

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

___ Anemia	___ Chronic Sinus	___ Hearing	___ Mastoid	___ Thyroid
___ Asthma	___ Convulsions	___ Heart	___ Measles	___ Tuberculosis
___ Bladder	___ Diabetes	___ Kidney	___ Mononucleosis	___ Other
___ Cerebral Palsy	___ Epilepsy	___ Liver	___ Mumps	___ Venereal Disease
___ Chicken Pox	___ Fainting	___ Malignancies	___ Rheumatic Fever	

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

_____

_____

CONSENT FOR DENTAL TREATMENT

I hereby grant authority to JEFFERY S. WEBB, DDS, and/or to the dentist(s) in charge of the care of the patient whose name appears above, to administer treatment or anesthetics and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

I understand that I am responsible for all costs of dental treatment and a 11/2% service charge will be made on accounts 90 days past due (18% per year) unless prior arrangements have been made.

I hereby authorize the release of any information including the diagnosis and/or the records of any treatments or examinations rendered to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement of insurance benefits to which I am entitled directly to the doctor.

Parent or Guardian Signature _____ Date _____