

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

YES NO

Date of last visit to a dentist _____

Does your child brush teeth daily _____

For what service _____

Do you assist child with tooth brushing _____

_____ YES NO

How often _____

Has child complained about dental problems _____

Is dental floss used _____

How often _____

Any unhappy dental experiences _____

Are disclosing tablets used _____

Is fluoride taken in any form _____

Any injuries to mouth - teeth - head _____

Child's attitude to dentistry _____

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

Do you desire complete dental service for the child _____

Any unusual speech habits _____

Any lost teeth _____

Summary (for doctor's use) _____

Have missing teeth been replaced _____

Orthodontic appliances worn now or ever been _____

HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

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

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

- | | | | | |
|---|--|---------------------------------------|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Sinus | <input type="checkbox"/> Hearing | <input type="checkbox"/> Mastoid | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver | <input type="checkbox"/> Mumps | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Malignancies | <input type="checkbox"/> 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 _____