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 ______