W. Randy Weber D.D.S.

CHILDREN'S REGISTRATION & HEALTH HISTORY QUESTIONNAIRE

Child's Name _____ Date _____

Home Address _____ City _____ State _____ Zip _____

Home Phone Number _____

Birthdate _____ Child's Social Security Number _____ **CHILD'S AGE** _____

Any Brother's and/or Sister's? _____ Age(s) _____

FATHER'S NAME _____ **MOTHER'S NAME** _____

Address _____ Address _____

Home Phone _____ Home Phone _____

Employer _____ Employer _____

Work Phone _____ Work Phone _____

SSN _____ SSN _____

Birhtdate _____ Birhtdate _____

Do you have Dental Insurance? _____

Name of Insurance Company? _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____ Who referred you? _____

DENTAL HEALTH HISTORY - CHILD...

Is this your child's first dental visit? _____

What is the child's attitude towards this visit? _____

Date of last dental treatment? _____

What was the last dental appointment for? _____

_____

Reason for this appointment? _____

Does your child ever have dental pain? _____ If so when? _____

_____

Did your child ever have a negative dental experience? _____ Explain: _____

_____

Mouth habits: _____ Thumb Sucking _____ Mouth Breathing _____ Bottle Nursing

Has your child had teeth removed? _____

How often does your child brush? _____ Floss? _____

Has your child received any fluoride treatment? _____ _____ Pill/Vitamins _____ Topical _____ Water

Are you happy with the appearance of your child's teeth? _____

Parent or Guardian's Signature _____

A + Printing

- Turn Over Please -

MEDICAL HEALTH HISTORY - CHILD...

Date _____

Child's general health (Please Check)

_____ Excellent _____ Good _____ Fair _____ Poor

Who is your child's physcian? _____

Address? _____

When did your child have last complete physical examination? _____

Is your child being treated for anything now? _____

Did your child ever have (Please Check):

_____ Anemia _____ Hearing Problems _____ Liver Disease

_____ Asthma _____ Heart Trouble _____ Rheumatic Fever

_____ Diabetes _____ Hepatitis _____ Speech Impediment

_____ Epilepsy/Convulsions _____ Kidney Disease _____ Tuberculosis

_____ Other

Is your child allergic to (Please Check):

_____ Penicillin _____ Codeine _____ Novocaine _____ Other

Is your child taking any medications now? _____ If so, what? _____

_____

Does your child have any allergies? _____

Is your child subject to prolonged bleeding? _____

AUTHORITY TO TREAT

Consent- I acknowledge that the above information is correct. I, being the parent, guardian or other person entitled to legal custody of the above mentioned minor child patient, hereby consent to and authorize the doctor to perform any and all forms of treatment, medication, therapy and patient management techniques that may be indicated in connection with the dental care of the patient. I undertstand that my dental insurance carrier may pay less than the actual bill for services, I agree to pay for all services rendered by this office the day of service. Remaining balance after insurance pays will be placed on your credit card, debit card or checking account. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month. In the case of default on payment of the account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balances. I understand that where appropriate, credit bureau reports may be obtained to offer financing for the services.

FINANCIAL POLICIES...

Please review our financial arrangement information sheet. Our office wants all patients to be able to comfortably afford dental care. Emergency treatment fees are due at the time of service.

Signature of Parent or Guardian _____ Date _____