WEISHAAR WEBER

CHILD REGISTRATION FORM

About Your Child

Child's Name _____ Nickname _____

☐ Male ☐ Female Date of Birth _____ School _____ Grade _____

How did you learn about our office? _____

Parent or Guardian

Legal Name _____ Relationship _____

Mailing Address _____

Home Phone _____ Cell Phone _____ Email _____

Appointment Reminders: circle your preference: Home Phone Cell Text Email Post Card Opt out

Child lives with: circle Parents Mother Father Legal Guardian Other _____

Person(s) responsible for payment of account _____

Employer _____ Employer Address _____

Occupation _____ Years of employment _____ Business Phone _____

Dental Insurance

Primary Insurance Company _____ Group # _____

Subscriber's SSN _____ Subscribers DOB _____ Relationship _____

Secondary Insurance Company _____ Group # _____

Subscriber's SSN _____ Subscribers DOB _____ Relationship _____

Emergency Contact

Name _____ Phone # _____ Relationship _____

Authorization and Release

I authorize Weishaar & Weber Dental to release any information including the diagnosis and the records of any treatment or examination rendered the child listed above during the period of such dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier **may pay less than the actual bill for services**. I agree to be responsible for payment of all services rendered to me or my dependents. *I authorize Weishaar & Weber to use my picture and/or photos of my mouth and teeth for advertising and/or marketing in print or on our website or social media.*

Signature _____ Today's Date _____

Financial Responsibility

I understand that the responsibility of payment for dental services provided in this office for myself or my dependents is mine, **due and payable at the time services are rendered** unless prior financial arrangements have been made. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or on any future outstanding account balances. I realize that failure to keep this account current may result in being unable to have any additional dental services provided.

Signature _____ Today's Date _____

updated 3-2016

SUE WEISHAAR.DDS ANTHONY WEBER.DDS

Enhancing Lives with a Friendly and Professional Experience

WEISHAAR WEBER

CHILD'S DENTAL & MEDICAL HISTORY

Your Child's Dental History - please circle correct answer

Office Notes Column

Is this your child's first visit to the dentist? Yes No If no, please list previous dentist _____

Is your child currently having any dental concerns, problems, toothaches? _____

Does your child have any concerns about their visit today? _____

Has your child had any problems with dental treatment in the past? _____

Had your child ever had any sedatives for dental treatment? Yes No Nitrous Oxide/laughing gas? Yes No

Have dental images (X rays) been taken? Yes No How did the child tolerate this? Easy OK Not so easy

Is your child taking any fluoride supplements? Yes No If not, could you share why? _____

Has your child ever suffered any injuries to the mouth, head or teeth? _____

How many times a day are the child's teeth brushed? _____ When are the teeth brushed? AM PM Other _____

Does the child suck his/her thumb, pacifier, etc? Yes No Does your child breath through his/her mouth? Yes No

Has your child had their tonsils/adenoids removed? Yes No Had problems with ear infections? Yes No

Does your child: Snore at night? Yes No Stop breathing at night? Yes No Bedwetting Yes No Grind Teeth Yes No

Has your child had any orthodontic procedures? Yes No If yes, what? _____

Medical History

Child's Pediatrician _____ Phone Number _____

Date of last physical exam _____ Are your child's immunizations, including tetanus, up to date? Yes No

Is your child in good health? Yes No If no, what illness is being treated? _____

Has your child had any allergies or reactions to any medications? If yes, please describe _____

Does your child have any allergies to the following? Latex Pollen Perfumes Other _____

Is your child currently taking any **prescription or OTC medications, vitamins?** Please give medication, dose and reason:

Has your child ever been hospitalized, or had general anesthesia? No Yes - For what? _____

Please circle if your child has been treated for any of the following:

Heart Disease	Asthma	Speech/hearing	Seizures	Cleft lip/palate
Heart Murmur	Tuberculosis	Jaw/TMJ pain	Anemia	Congenital birth defects
Kidney Disease	Respiratory Illness	Frequent Infections	Diabetes	Brain Injury
Liver Disease	Reflux/GERD	Recurrent headaches	Arthritis	Drug Addiction
Hepatitis	Blood disease	Cold Sores	Eyesight	Autism
Rheumatic fever	Pregnant	AIDS/HIV +	Seizure	ADD/ADHD
Mental, Emotional or Developmental delays _____				Physical / Mental Abuse

Other _____

Other - please circle those that apply to your child

outgoing high strung anxious friendly stubborn shy cooperative laid back curious cautious talkative

Is there anything else about your child we should be aware of? _____

_____

I affirm that the above information above is correct to the best of my knowledge. I will not hold the dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors of omission that I may have made in the completion of this form.

Signature _____ Today's Date _____

updated 3-2016