

**George L Hess III DDS
3003 Superior Ave
Sheboygan, WI 53081**

Child Registration & Medical History

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ School: _____ SS# _____

If this is your child's first visit, whom may we thank for referring you to our practice? _____

Name of Person Responsible for Account: _____

Father's Name: _____ Mother's Name: _____

Address: _____ Address: _____

Home Phone: _____ Work Phone: _____ Ext or Dept. _____ Home Phone: _____ Work Phone: _____ Ext or Dept. _____

Place of Employment: _____ Place of Employment: _____

Soc. Sec. #: _____ Date of Birth: _____ Soc. Sec. #: _____ Date of Birth: _____

Date of your child's last dental visit: _____ What was done? _____

Child's Hobbies: _____ Has your child ever had a habit of thumb sucking? _____

Health Information

Is your child allergic to: Penicillin Codeine Local Anesthetic Latex Other _____

Please check if your child has or ever had:

Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthetic Implant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis/Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	A.D.D.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Urination/Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other: _____

