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

Other:_____

If yes to any, please explain

Is your child experiencing discomfort at this time? ❑ Yes ❑ No _____
Is he/she apprehensive about having dental treatment? ❑ Yes ❑ No _____
Has he/she ever had a bad experience at a dental office? ❑ Yes ❑ No _____

Does your child brush his/her teeth daily? ❑ Yes ❑ No How often?_____
Does your child floss his/her teeth? ❑ Yes ❑ No How often?_____

Is your child taking any medication? ❑ Yes ❑ No
If yes, please list:_____
Has your child seen an orthodontist? ❑ Yes ❑ No Name of orthodontist:_____
Name of child's physician:_____

The information present on these pages is true to the best of my knowledge. The undersigned authorizes Dr. George Hess to take x-rays, study models, photographs, or other diagnostic materials deemed appropriate by Dr. Hess to make a thorough diagnosis of my dental health condition. I authorized Dr. Hess to perform any and all forms of treatment, medication, and therapy which maybe indicated in connection with the services required for my dental health. I understand that Dr. Hess will discuss treatment before beginning. I further authorize and consent that Dr. Hess choose and employ such assistance as deemed fit.

I understand that the responsible for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made. In the event of default, I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

Accounts 30 days past due are assessed 1.5% per month.

Signed:_____Date:_____

Health History Update

Health & Medication Changes:_____Signature:_____ Date:_____

Health & Medication Changes:_____Signature:_____ Date:_____

Health & Medication Changes:_____Signature:_____ Date:_____

Health & Medication Changes:_____Signature:_____ Date:_____

Health & Medication Changes:_____Signature:_____ Date:_____

Health & Medication Changes:_____Signature:_____ Date:_____

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