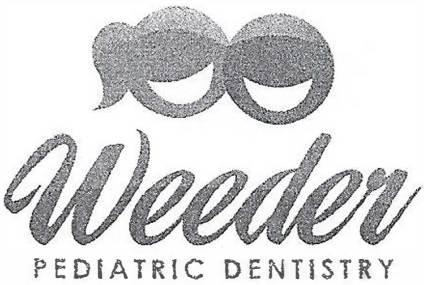

Patient Registration and Medical/Dental History

We would like to welcome you and your child to Weeder Pediatric Dentistry. Our practice is based on preventive dental care and our primary goal is to make every visit fun and educational. We strive to teach good oral care that will enable your child to maintain and share a beautiful smile for a lifetime!

ABOUT YOUR CHILD

Patient's Name _____ Preferred Name _____

Date of Birth _____ ☐ Male ☐ Female

Home Address _____ Home Phone _____

City _____ State _____ Zip Code _____

How did you hear about our office?

☐ Friend _____ ☐ Dr. Referral ☐ Paper ☐ Internet ☐ Other _____

- O Facebook
- O Website

PERSONS RESPONSIBLE FOR ACCOUNT

PARENT OR LEGAL GUARDIAN INFORMATION

Name: _____ Date of Birth: _____

Mailing Address: _____ Social Security #: _____

City, State, Zip: _____ Home Phone: _____

Employer: _____ Work Ph: _____

E-mail Address: _____ Cell Ph: _____

PARENT OR LEGAL GUARDIAN INFORMATION

Name: _____ Date of Birth: _____

Mailing Address: _____ Social Security #: _____

City, State, Zip: _____ Home Phone: _____

Employer: _____ Work Ph: _____

E-mail Address: _____ Cell Ph: _____

EMERGENCY INFORMATION

In case of an emergency where neither parent nor legal guardian can be reached, please identify the following information for the next closest relative not living with the parent.

Name _____ Relation _____ Home Phone _____

Address _____ Cell Phone _____

MEDICAL HISTORY

Patient's Name _____

Has your child ever had any of the following conditions?

Yes	No		Yes	No		Yes	No	
☐	☐	Anemia/Low Blood Count	☐	☐	Hearing Impairments	☐	☐	Anemia/Low Blood
☐	☐	Heart Condition	☐	☐	Kidney Disease or Transplant	☐	☐	Heart Condition
☐	☐	Rheumatic/Scarlet Fever	☐	☐	Hepatitis or Liver Disease	☐	☐	Rheumatic/Scarlet Fever
☐	☐	Cancer, Malignancies or Leukemia	☐	☐	Child Abuse			_____
☐	☐	Asthma	☐	☐	Infection			
☐	☐	Diabetes	☐	☐	Cleft Lip/Palate			
☐	☐	Epilepsy, Seizures or Convulsions	☐	☐	Cerebral Palsy			
☐	☐	Hyperactivity/ADD	☐	☐	Birth Defects			
☐	☐	Psychiatric Care	☐	☐	Developmentally Delayed			
☐	☐	Latex Allergy or Sensitivity	☐	☐	Tuberculosis or Previous Positive Test			
☐	☐	Pain in Jaw Joints	☐	☐	Autism			
☐	☐	Excessive Bleeding/Hemophilia	☐	☐	Food Allergies? To What? Especially Eggs. _____			

☐ ☐ Is Pre-Med necessary due to a heart condition or other medical reason?

☐ ☐ Is the patient currently taking any medication(s)? (If yes, please list)

_____

☐ ☐ Is the patient currently under the care of a physician? (If yes, for what?)

_____

☐ ☐ Is your child allergic or has your child ever had an adverse reaction to a specific medication? (If yes, which?)

_____

PLEASE LIST ANY TREATING DOCTOR (I.E. PEDIATRICIAN)

Type Of Doctor _____ Name _____ Office Phone _____

DENTAL HISTORY

Has your child ever suffered from any of the following conditions?

Yes	No		Yes	No	
☐	☐	Bad Breath/Halitosis	☐	☐	Dental Infection or Abscess
☐	☐	Bleeding Gums	☐	☐	Recent Dental Pain
☐	☐	Stained and Discolored Teeth	☐	☐	Missing or Extra Teeth
☐	☐	Cold Sores or Fever Blisters	☐	☐	Thumb/Finger Sucking
☐	☐	Dry Mouth	☐	☐	Dental Grinding/Clenching

☐ ☐ Do you wish to talk to the doctor privately about any special concerns?

☐ Has your child experienced any unfavorable reaction from previous medical or dental care? (If yes, please explain)

_____

☐ ☐ Injury or Trauma to Teeth, Mouth or Face (If yes, please explain)

_____

☐ ☐ Does your child receive fluoride supplementation from vitamins, water or tablet/drops?

How do you think your child will act toward the dentist?

☐ Cooperative ☐ Fearful ☐ Defiant ☐ Don't Know

Parent/Legal Guardian Signature _____ Date _____

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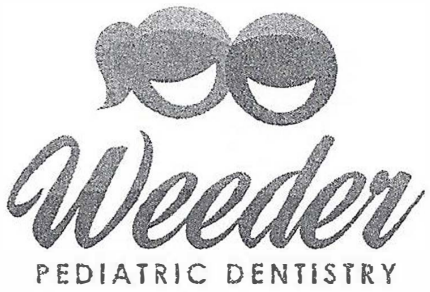

Primary Insurance Co. _____ Ins. Co. Phones _____
Primary person on policy? _____ I.D.# _____
Date of Birth _____ Group # _____
Employer _____

Secondary Insurance Co. _____ Ins. Co. Phones _____
Primary person on policy? _____ I.D.# _____
Date of Birth _____ Group # _____
Employer _____

MEDICAL/DENTAL RELEASE STATEMENT

I give my consent for the dentists at Weeder Pediatric Dentistry to do a complete and thorough examination on the patient previously named, including any diagnostic x-rays needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest confidence. Furthermore, I understand that it is my responsibility to inform Weeder Pediatric Dentistry of any future changes to my child's medical status. As the parent or legal guardian of the previously named patient, I do hereby grant Weeder Pediatric Dentistry and its staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved. Initial

REQUIREMENT FOR FILING INSURANCE CLAIMS

To expedite the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within thirty (30) days of treatment. I hereby authorize payment of insurance benefits directly to Weeder Pediatric Dentistry or the dentist that performs treatment on my child. In the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

Parent/Legal Guardian Signature _____ Date _____

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Weeder
PEDIATRIC DENTISTRY

LEGAL CONSENT TO MAKE DECISIONS

PATIENT'S NAME _____

As a convenience, we would like to offer you a chance to provide Weeder Pediatric Dentistry with a list of individual(s) that may accompany your child to subsequent visits. Listing an individual will provide them with your legal consent to make both treatment and financial decisions on your behalf.

With this list, a family member, step-parent, or good friend would have the authority to accompany your child to the dental appointment and make decisions without the need of any additional written or verbal consent. If not listed, patients must always be present with a parent or legal guardian. Please only provide the names of those individuals that you trust to make such decisions as treatment changes, to make payments, and to discuss medical and financial information. Please remember, individuals that are permitted to make treatment decisions will also be responsible for any incurred payment changes.

We, as an HIPAA compliant healthcare facility, will use our best discretion to maintain all personal information and will only provide the individuals listed below with information needed to make a specific decision on your behalf. Information will only be provided on a need-to-know basis and we will not allow these individuals to have or copy your child's dental chart. We simply want to make treating your child in our facility as convenient as possible for you.

Please identify such individuals and initial your decision to allow them to provide consent to make treatment decisions, to make financial arrangements, or both. Please remember that individuals accompanying your child to an appointment will be responsible for additional charges incurred during that particular visit.

CONSENT TO MAKE DECISIONS

Individual's Name	Relationship

As the parent or legal guardian of the patient noted above, I do hereby provide the individuals listed beneath the chart entitled "Consent to Make Decisions", the legal authority to make decisions in my absence. I also understand that these decisions may change or alter previous treatment recommendations or charges that I have already agreed to and that I, as this child's parent or legal guardian, am ultimately responsible for any new charges incurred as a result of treatment decisions made by any individual listed above.

Parent or Legal Guardian Signature _____ **Date** _____

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Parent Guidelines

Dear Parents,

You may choose whether or not you accompany your child during their dental appointments. Some children do better without parents present, but we are open to parents helping us figure out which works best for each child. If you choose to be present, we suggest the following guidelines to improve chances of a positive outcome:

- Allow us to prepare your child
- Be supportive of the practice's terminology
    - we don't use "needles" or "shots", we use " sleepy water" so your tooth can't feel anything
    - We don't "drill" teeth, we "wash" them
    - We don't "pull" teeth, we "wiggle" or "dance" them
    - "Be brave" is NOT a useful phrase; this implies there is something to fear. Instead please encourage them to "be a good helper"
- Please be a silent observer. Holding your child's hand is a good option for showing your child you are there to support them
    - This allows us to maintain communication with your child
    - Children normally listen to their parents instead of us and may not hear our guidance
    - You might give incorrect or misleading information
- If asked to leave the room please understand this is intended to regain child's focus on the doctor so he can better assist your child
    - We will continue to support your child at all times
    - If you choose to not accompany your child you can always ask a member of the team to check on your child and give you an update
- We ask that all siblings remain in the waiting room for the duration of the appointment
    - If siblings are not old enough to play in waiting room with minimal supervision please remain with them so that we can proceed with your child's treatment without interruption

These are very important ways that you can actively help in the success of your child's visit. We are confident that all will go well and hope these guidelines will help prepare you with confidence for the upcoming appointment.

Signed: _____ Date: _____