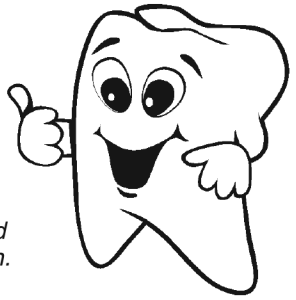
DESERT DENTAL
Ryan M. Wieseler, D.D.S.

995 W. Orchard Avenue • Hermiston, Oregon 97838 • (541) 567-8161

CHILD



Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Date:_____

PATIENT INFORMATION

Patient #_____

Name of Minor/Child_____
First Name Initial Last Name

Sex ❒ M ❒ F Age_____ Birthdate _____ Nickname_____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Person financially responsible _____ Home Phone _____ Work Phone _____

Email _____ Cell Phone_____

Preferred Method of Contact: ❒ Cell Phone ❒ Email ❒ Home Phone ❒ Work Phone

Whom may we thank for referring you? _____

PARENT INFORMATION & INSURANCE INFORMATION

Father's/Guardian's Name_____

Address (if different from patient's) _____

_____

Home Phone _____ (if different from above) Work Phone _____ (if different from above)

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐Yes ☐No

Plan Name_____

Phone No. _____

Address _____

_____

Group # _____

Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone _____ (if different from above) Work Phone _____ (if different from above)

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐Yes ☐No

Plan Name_____

Phone No. _____

Address _____

_____

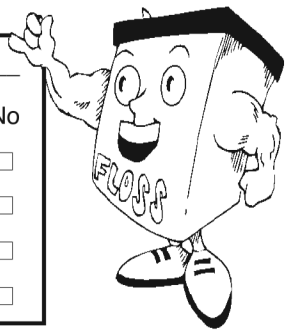
Group # _____

Policy # _____

I have reviewed the treatment plan. I authorize release of any information relating to this claim.
I hereby authorize payment directly to the above-named dentist of the group insurance benefits otherwise payable to me.

_____ _____
Signed (Patient or Parent if Minor) Date

DENTAL HISTORY



Date of last visit to a dentist _____ For what service? _____

	Yes	No		Yes	No
Has child complained about dental problems? ..	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Dose child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?	☐	☐			

Please Complete Both Sheets

MEDICAL HISTORY

CHILD

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	Yes	No	
Is Minor/Child under care of physician now?	☐	☐	Medications _____
Receiving any medication of drugs?	☐	☐	_____
Ever been hospitalized?	☐	☐	_____
Ever had surgery?	☐	☐	Allergies _____
Is there excessive bleeding when cut?	☐	☐	_____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK (√)

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Turberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact? Other than home phone.

Name _____ Relationship _____

Phone _____ Cell Phone _____

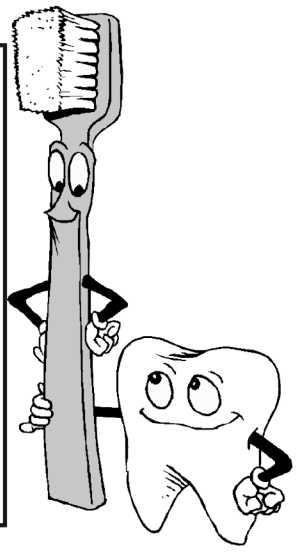
Name _____ Relationship _____

Phone _____ Cell Phone _____

MISSED AND LATE/CANCELLED APPOINTMENT POLICY

24 business hours cancellation notice required. At the second failed or late/cancelled appointment, a fee of $50 will be billed. A third failed or late/cancelled appointment may result in dismissal from our practice.

AUTHORIZATIONS

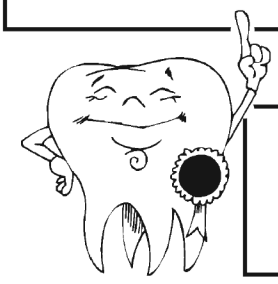


The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my Minor/Child. I realize radiographs and clinical photographs are used for diagnostic and treatment planning purposes. They may also be used as educational and teaching aids. I authorize the use of radiographs and photographs for these purposes.

I understand and acknowledge that I am financially responsible for the services provided for my child regardless of insurance coverage. I also understand, if I have co-insurance this office will initially bill said insurance. And that I will be responsible for follow-up and collections from the secondary insurance. I further understand that a 1% finance charge (12% annually) will be added to any balance over 60 days. Returned checks will be assessed a fee of $25.00.

_____ _____ DATE: _____

(Signature fo Responsible Party) Relationship to Child



UPDATE

Update _____ Update _____ Update _____ Update _____

Update _____ Update _____ Update _____ Update _____