Maddox DENTISTRY
EXCELLENCE IN ORAL HEALTHCARE
1100 RICKARD RD. SPRINGFIELD, ILLINOIS 217.546.4738
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CHILD REGISTRATION & HEALTH HISTORY FORM

Child's Name	Nickname	Home Phone	Date of Birth
Home Address			
Father's Name	Occupation	Employer	Phone
Mother's Name	Occupation	Employer	Phone
Person Responsible for Account		Address	Zip
Dental Insurance Co.		Social Security # of Insured	

Person to contact in case of emergency_____ Phone_____

Whom may we thank for referring you to our office? _____

Is the child currently under a physician's care? _____

If yes, please provide physician's name, address, & phone: _____

HAS A PHYSICIAN INFORMED YOU OR HAS YOUR CHILD HAD ANY OF THE FOLLOWING:

☐ Heart Ailment
☐ Rheumatic Fever
☐ Epilepsy
☐ Liver Disease
☐ Kidney Disease
☐ Hypoglycemia
☐ Asthma
☐ Diabetes

Does the child have any known allergies? Yes ☐ No ☐ If yes, please list:_____

Is the child currently taking drugs or medications? Yes ☐ No ☐ If yes, please list: _____

What is the medication for? _____

Comments _____

I, _____(the Parent/Guardian of patient) hereby authorize Dr. Wm. Sturm/Dr. Brandon Maddox to perform such dental services as he deems necessary, to administer anesthetics as he deems necessary, and to perform any and all other technical or dental procedures which in the judgment of said Dentist may be necessary or advisable for the welfare of the patient. To the best of my knowledge, all of the preceding answers and information provided are true and correct. If the patient has any change in their health I (the Parent/Guardian) will inform the doctors at the next appointment without fail. I (the Parent/Guardian) understand that I am financially responsible for all charges rendered, whether or not paid by an insurance carrier, and balances over 60 days will be charged a monthly service fee of 1.5% (18% APR) for each month the balance is carried. In the case of default, I I (the Parent/Guardian) promise to pay any legal interest on balances due together with any collection costs and reasonable attorney's fees incurred to affect collection of this account. I (the Parent/Guardian) understand credit bureau reports may be obtained. I (the Parent/Guardian) have reviewed and/or received a copy of this office's Notice of Privacy Practices. I (the Parent/Guardian) agree to have any photos taken of my child's face or mouth to be used for educational and training purposes. This is to serve as my "signature on record."

SIGNATURE _____ DATE _____