

CHILD'S REGISTRATION AND HISTORY

DATE _____

CHILD'S NAME _____ CALL NAME _____ AGE _____ BIRTHDATE _____

CHILD'S S.S. # _____

SCHOOL _____ GRADE _____

HOME ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____ E-MAIL ADDRESS _____

FATHER'S NAME _____ CALL NAME _____ FATHER'S BIRTHDAY _____

FATHER'S S.S. # _____ DRIVER'S LICENSE # _____ STATE _____

FATHER EMPLOYED BY _____ POSITION _____ HOW LONG _____

FATHER'S BUSINESS ADDRESS _____ BUSINESS PHONE _____

MOTHER'S NAME _____ CALL NAME _____ MOTHER'S BIRTHDAY _____

MOTHER'S S.S. # _____ DRIVER'S LICENSE # _____ STATE _____

MOTHER EMPLOYED BY _____ POSITION _____ HOW LONG _____

MOTHER'S BUSINESS ADDRESS _____ BUSINESS PHONE _____

PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN PARENT) _____

RELATION TO CHILD _____

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICE _____ YES _____ NO

IF SO NAME OF PRIMARY COMPANY _____

S.S. # OF POLICY HOLDER _____

SECONDARY INSURANCE COVERAGE, IF ANY _____

WHAT IS YOUR CHILD'S FAVORITE SPORT _____ TOY _____ HOBBY _____

WHO IS THIS CHILD'S FAVORITE PERSON _____ FICTIONAL CHARACTER _____

DOES THE CHILD HAVE ANY MOUTH HABITS: THUMBSUCKING, NAIL BITING, MOUTH BREATHING, ETC. _____

ARE THERE ORTHODONTIC APPLIANCES WORN NOW OR EVER BEEN? _____

WHOM MAY WE THANK FOR REFERRING YOU _____

HEALTH HISTORY

CHILD'S PHYSICIAN _____ ADDRESS _____ PHONE _____

DATE OF LAST PHYSICAL EXAMINATION _____ RESULTS _____

| | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Is child under care of physician now _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> | Does child have good physical coordination _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Is child receiving any medication or drugs _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> | Are there any emotional problems _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there any excessive bleeding when cut _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> | Has child any history of or difficulty with any of the following: | | |
| | | | ___Aids | ___Epilepsy | ___Mastoid |
| Has child ever been hospitalized _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> | ___Anemia | ___Fainting | ___Measles |
| | | | ___Asthma | ___Hearing | ___Mononucleosis |
| Has child ever had surgery _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> | ___Bladder | ___Heart | ___Mumps |
| | | | ___Cerebral Palsy | ___HIV | ___Rheumatic fever |
| Is there any allergy to penicillin or other drugs _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> | ___Chicken pox | ___Implants | ___Thyroid |
| | | | ___Chronic sinus | ___Kidney | ___Tuberculosis |
| Are there other allergies: food - pollen - animals - dust - other _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> | ___Convulsions | ___Liver | ___Venereal Disease |
| | | | ___Diabetes | ___Malignancies | ___Other |

This information was given by _____
Relation to child _____

I AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES ON THIS ACCOUNT FOR ALL PRESENT AND/OR FORMER FAMILY MEMBERS.

Payments are due and payable at Kellum Dental Clinic, P.A.'s (hereinafter, "Kellum"), place of business in Tupelo, Mississippi and Debtor submits to the jurisdiction and venue of the state courts of Lee County, Mississippi for enforcement of this contract/payment of this account. If this bill is referred for collection, Debtor agrees to pay Kellum an additional 33 1/3% of the original bill (including interest, \$150.00 minimum) as attorney fees, plus all costs of collection to include court costs. As part of the consideration for the extension of credit, Debtor hereby waives any exemptions, as to Kellum, allowed by federal (to include bankruptcy) or state law as to execution by Kellum on property or assets of the Debtor or surety for satisfaction for this debt. Debtor agrees to pay interest on all overdue bills at the rate of 1.75% per month (21% annual percentage rate) or such other lesser amount as is allowed by the laws of Mississippi.

SIGNATURE _____ DATE _____