Pediatric Dental Specialists of Central Oklahoma

WELCOME

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PATIENT INFO

Date_____ Child SS # _____ Birthdate_____

Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last First Middle Initial

Nickname _____ Hobbies _____ Home Phone (____)-_____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____

Person financially responsible _____ Parents' Marital Status ☐ M ☐ D ☐ W ☐ S

Whom may we thank for referring you? _____ Former Dentist. _____

INSURANCE

Father's / Guardian's Name _____

Address (if different from patient's) _____

_____

Dad's Cell (____)-_____ Work Phone (____)-_____

E-mail _____

Occupation _____

Employer _____

Soc. Sec. # _____ Birthdate_____

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

Plan Name _____ Phone (____)-_____

Group # _____ Policy # _____

Mother's / Guardian's Name _____

Address (if different from patient's) _____

_____

Mom's Cell (____)-_____ Work Phone (____)-_____

E-mail _____

Occupation _____

Employer_____

Soc. Sec. # _____ Birthdate_____

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

Plan Name _____ Phone (____)-_____

Group # _____ Policy # _____

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?	☐	☐
Does 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 Sides

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (___)-_____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

_____

Allergies: If yes, please check (✓).

☐ Local Anesthetic (e.g., Novocaine)
☐ Penicillin or any other antibiotic
☐ Sulfa Drugs
☐ Barbiturates
☐ Sedatives
☐ Latex Rubber
☐ Any Metals (e.g. nickel, mercury)
☐ Other

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	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

In the event of an emergency, besides others on this form who should we contact?

Name _____ Relationship _____ Phone (___)-_____

Name _____ Relationship _____ Phone (___)-_____

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr._____ all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Parent, Guardian or Personal Representative — Relationship to Patient

DR.

FOR DOCTOR'S USE _____

_____