WELCOME TO OUR OFFICE

Dr. Rob Oliver and Associates

Pediatric Dentistry

Child's Name_____ Date of Birth_____ Age _____ Sex M F

Is this your child's first dental visit? Yes____ No____

If no, name of previous dentist_____ Last visit_____

Purpose of this visit_____

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

GENERAL INFORMATION

Parent/Guardian #1_____ DOB: _____SSN_____
Marital status: married ___single ___divorced ___partner___

Address: _____City_____Zip_____

Home Phone_____ Cell Phone_____ E-mail _____

Employer_____ Work Phone_____

Relationship to patient_____

Parent/Guardian #2_____ DOB:_____SSN_____
Marital status: married ___single ___divorced ___partner___

Address: _____City_____Zip_____

Home Phone_____ Cell Phone_____ E-mail_____

Employer_____ Work Phone_____

Relationship to patient _____

Emergency Contact_____Relationship_____Phone#_____
(excluding parents)

Authorization and Release

I authorize the dentist/dental staff to perform the necessary dental services that my child may need. I also authorize the dentist/dental staff to release any information including diagnosis and/or x-rays rendered, to my child during the period of such care to any third party payers and or health providers. I certify that I am financially responsible for the above named patient and any charges that may occur. I further acknowledge the receipt of the HIPPA Privacy Form.

Signature of Parent/Guardian: _____ **Printed Name:** _____**Date:**_____

Dental/Medical Questionnaire

Child's Name_____ Child's Pediatrician_____

Is your child under a physician's care now? Yes___ No___ If so for what reason? _____

Is your child taking any medication or drugs? Yes___ No___ Please list_____

For what reason? _____

Is your child allergic to any medications? Yes___ No___ Please list_____

Does your child have allergic reaction to: food____ animals____ pollen____ dust____ latex____ other _____
Does your child have any of these habits: finger/thumb sucking ___ pacifier___ nail biting ___ teeth grinding ___
lip sucking ___ snoring ___ mouth breathing ___
Does your child complain of any dental problems? Yes___ No___ Please describe _____

Has your child had any injuries to teeth, mouth or head? Yes___ No___ Please describe_____

Has your child had a history or difficulty with any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	Premature Birth	___	___	Delayed Development	___	___	Emotional	___	___	Anxiety
___	___	Heart	___	___	Autism			Problems	___	___	Behavior Issues
___	___	Seizures	___	___	Asthma	___	___	Speech Disorder	___	___	Sensory
___	___	Immune disorder	___	___	Kidney	___	___	Hearing	___	___	ADHD/ADD
___	___	Brain injury	___	___	Cerebral Palsy	___	___	Anemia	___	___	Rheumatic fever
___	___	Diabetes	___	___	Fainting or dizziness	___	___	Liver	___	___	Tuberculosis
___	___	Hepatitis	___	___	Cancer or malignancies	___	___	Bladder	___	___	Bone disorder

Additional Information: _____
The above statements are to the best of my knowledge, true and correct. I agree to report any health changes to the dentist before any treatment performed ____ (initial)
Please tell us some interests of your child in order to help us create a positive relationship_____

DENTAL INSURANCE INFORMATION

Insured Parent #1 _____ Relationship to patient_____

Social Security Number_____ Date of Birth_____ _Ins ID #_____

Employer_____ Name of Insurance Co. _____Group Policy #_____
Insurance Co Phone #_____
(Please fill out below only if two dental insurance plans are available for child)

Insured Parent #2 _____ Relationship to patient_____

Social Security Number_____ Date of Birth_____ _Ins ID #_____

Employer_____ Name of Insurance Co. _____Group Policy #_____
Insurance Co. Phone #_____

Assignment of Benefits: I hereby authorize payment directly to the above named dentist of the group dental benefits otherwise payable to me. I understand that I am financially responsible for 100% of all charges incurred regardless of any insurance benefits .

Signature: _____ Date: _____