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www.OverlandParkDentist.com

1 ABOUT YOUR CHILD

Name: _____
Last First M

Nickname: _____

Birth Date: _____/_____/____ Male Female

Social Security # : _____

School: _____ Grade: _____

Home Address: _____
Apt #

_____
City State Zip Code

Home Phone: _____

Referred By: _____

2 *ABOUT YOU*

Your Name: _____
Last First M

Relationship to child: _____

Person Responsible for child: _____

Your home phone and address if different from child's:

Home Address: _____
Apt #

_____
City State Zip Code

Home Phone: _____

Occupation: _____

Employer: _____

Work Phone: _____

Email Address: _____

3 INSURANCE

DENTAL INSURANCE COMPANY #1

Do you have dental insurance?
Yes No

Group #: _____

This Dental Insurance is provided through:

Their name: _____

Relationship to Child: _____

Their Social Security #: _____

Their Birth Date: _____

Their Employer: _____

_____

DENTAL INSURANCE COMPANY #2

Do you have Secondary dental insurance?
Yes No

Group #: _____

This Dental Insurance is provided through:

Their name: _____

Relationship to Child: _____

Their Social Security #: _____

Their Birth Date: _____

Their Employer: _____

_____

4 MEDICAL/DENTAL HISTORY

Has your child been to the dentist before?

Yes No

If yes, the approximate date of last visit:

_____

Are there any dental problems that you are aware of at present time? Yes No

If yes, please explain: _____

_____

Does your child brush his/her teeth daily?

Yes No

Is your child currently under the care of a physician?

Yes No

Child's Physician: _____

Their Phone #: _____

Is your child allergic to any drugs?

Yes No

If yes, please list: _____

_____

Does your child need to be pre-medicated for artificial joints, heart murmer or mitral valve prolapsed before dental treatment?

Yes No

5 MEDICAL/DENTAL HISTORY

Has your child ever had any of the following medical conditions or problems?

Please Circle

Y	N	Heart Murmur
Y	N	Heat problems of any kind
Y	N	Convulsions/Epilepsy
Y	N	Cancer
Y	N	Diabetes
Y	N	Rheumatic Fever
Y	N	HIV + / AIDS
Y	N	Hemophilia
Y	N	Bleeding problems of any kind
Y	N	Hearing Impairment
Y	N	Hyperactive
Y	N	Any Operations
Y	N	Any Stays in Hospital
Y	N	Other _____

I understand tha the information, that I have givien is corect to the best of my knowledge, that I will be held in the most strict of confidence and it is my responsibility to inform this office of any changes in my child's medical status, I also authrozie the dental staff to perform the necessory dental servies my child may need.

Signature of parent of guardian _____ Date: _____