

Dr. Rob Oliver, Children's Dentistry

Child's

Name _____ **Birthday** _____ **Age** _____ **M** **F** _____

Last dental visit _____ Child's previous dentist _____

Purpose of this visit _____

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

Health History

Child's Pediatrician _____

Is your child under a physician's care now? _____ Reason _____

Is your child taking any medication or drugs? _____ What kind _____ Reason _____

Is your child allergic to any medications? _____ 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 _____

Has your child had any injuries to teeth, mouth or head? _____ Describe _____

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

Yes	No	Yes	No	Yes	No	Yes	No
___	___	___	___	___	___	___	___
___	___	___	___	___	___	___	___
___	___	___	___	___	___	___	___
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___	___	___	___	___	___	___	___
___	___	___	___	___	___	___	___
___	___	___	___	___	___	___	___

Additional Information: _____

General Information

Parent/Guardian #1 _____ SS No _____ B/date _____

Address _____

Home Phone _____ Cell Phone _____ email _____

Relationship to Patient _____ Employer _____ Work Phone _____

Parent/Guardian #2 _____ SS No _____ B/date _____

Address _____

Home Phone _____ Cell Phone _____ email _____

Relationship to Patient _____ Employer _____ Work Phone _____

Person(s) financially responsible for child's dental care _____

The permission of parent or guardian is necessary for dental treatment. I give the dentist permission to use such measures as deemed necessary in his professional judgement to render the best dental treatment for my child, including the use of anesthetics and premedication considered necessary or advisable for the comfort and well-being of my child.

Signature _____ **Relationship** _____ **Date** _____

Insurance Information

Do you have dental insurance coverage for this child? _____

FATHER'S INSURANCE: Name of insurance company _____ Group # _____

Address of insurance company _____ Phone # _____

MOTHER'S INSURANCE: Name of insurance company _____ Group # _____

Address of insurance company _____ Phone # _____

I hereby authorize payment to Rob Oliver D.D.S. for the group dental benefits, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance.

Signature _____ **Relationship** _____ **Date** _____