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	
___	___	Premature Birth	___	___	Delayed Development	___	___	Emotional Problems	___	___	Nosebleeds
___	___	Heart	___	___	Autism				___	___	Asthma
___	___	Seizures	___	___	Cancer	___	___	Speech Disorder	___	___	Liver
___	___	Immune disorder	___	___	Kidney	___	___	Hearing	___	___	Bone disorder
___	___	Allergy to medicine	___	___	Cerebral Palsey	___	___	Brain injury	___	___	Rheumatic fever
___	___	Diabetes	___	___	Fainting or dizziness	___	___	Bruising	___	___	Tuberculosis
___	___	Hepatitis	___	___	Cancer or malignancies	___	___	Bladder	___	___	Anemia

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_____