GARY A OLEN, D.D.S., M.S., Inc.
MICHAEL MAURER D.D.S., M.S., Inc.
Pediatric Dentistry for Infants, Children and Adolescents

General Information

Child's full name _____ Nickname _____
Sex: F_____M_____childs date of birth _____ Age _____
Address _____ Apt.# _____ City/State _____ Zip _____
Home phone _____ Mother's cell _____ Father's cell _____
Email Address: _____
Whom may we thank for referring you to our office? _____
Father's Full Name _____ Social Security _____ D.O.B _____
Employed By _____ Occupation _____
Address _____ Business phone _____
Mother's Full Name _____ Social Security _____ D.O.B _____
Employed By _____ Occupation _____
Address _____ Business phone _____
Married_____ Widowed_____ Divorced_____ Separated_____ Single_____
Person Responsible for Childs Account _____
Names and ages of Brothers and Sisters _____
Previous Dentist _____ Address _____
Date of Last Dental Treatment _____
Name of Father's Dental Insurance _____ Group # _____
Name of Mother's Dental Insurance _____ Group # _____

Health Questionnaire

State condition of child's health-please be specific _____
Has your child ever been under the care of a physician? If yes, state why and when and the name of the physician _____
_____
Has your child received medication in the past other than antibiotics? If yes, for what and when? _____
Has your child received a blood transfusion or blood products? _____
Is your child a carrier of any infectious disease? _____
Has your child had any history of the following: heart trouble, rheumatic fever, brain injury, diabetes, hepatitis, convulsions, temper tantrums, seizures, asthma, bleeding disorders, AIDS, HIV, ARC? (please indicate) _____
Is your child adopted? _____
Is your child allergic to penicillin, anesthetic, any medication or food? _____
Is your child taking a fluoride vitamin or fluoride tablet? _____
Has your child had fluoride put on his or her teeth? _____
Has your child experienced any unfavorable or unpleasant reaction from previous dental or medical care? _____
Has any member of the family ever had an unusual dental history, such as missing or extra teeth? _____
Has there ever been any injury to any of your child's teeth by fall, blow, bump or otherwise? _____
Does your child have a history of osteoporosis or bisphosphonate use? _____
Does your child have any habits such as thumbsucking, nailbiting, lip or cheek biting? Please indicate _____
What school does your child attend? _____
Are there any health or other problems you feel should be brought to the attention of the doctor? _____
State name, address and phone number of child's physician _____
I hereby certify the foregoing information is true and correct.
Signature _____ Date _____
Relationship to patient _____

CONSENT-RESPONSIBILITY

1. I authorize the specialists to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with my child. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the specialist choose and employ such assistance as deemed fit to provide recommended treatment.
2. I understand that all responsibility for payment for dental services provided in this office to my child, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.
3. I understand that where appropriate, credit bureau reports may be obtained.
4. I authorize the use of my social security number to file my child's dental claim.

Parent/GuardianSignature _____ Date _____
Please Print _____