GARY A. OLEN, D.D.S., M.S., INC.
MICHAEL MAURER, D.D.S., M.S., INC.
PEDIATRIC AND ADOLESCENT DENTISTRY
773 Broadway • El Cajon, CA 92021
(619) 440-5915

UPDATED REGISTRATION AND HISTORY

TODAY'S DATE ________

CHILD'S Full Name ______________________ Age______ Date of Birth ____________
Address ______________________ Apt#_____ City______________ Zip__________
Home Phone (_______) ______________ Mom's Name______________ Mom's Cell (_____)__________
E-Mail ______________________ Dad's Name______________ Dad's Cell (_____)__________

HEALTH HISTORY

1. Has your child's medical history changed since your last visit to this office? ☐ Yes ☐ No
   PLEASE EXPLAIN______________________________
2. Has your child ever received a blood transfusion or blood products? ☐ Yes ☐ No
3. Is your child allergic to latex? ☐ Yes ☐ No
4. Is your child allergic to any antibiotics, anesthetic or any other medications? ☐ Yes ☐ No
   IF YES,______________________________
5. Does your child have any food allergies? ☐ Yes ☐ No
   IF YES,______________________________
6. Does your child have a history of AIDS, HIV or ARC? ☐ Yes ☐ No
7. Does your child have any developmental delays, disabilities, or mental disorders? ☐ Yes ☐ No
   PLEASE EXPLAIN______________________________
8. Does your child have a history of heart disease/murmur, kidney disease, brain injury, diabetes or other health issues? ☐ Yes ☐ No
   PLEASE EXPLAIN ______________________________
9. Is your child currently taking any medications? ☐ Yes ☐ No
   IF YES, ______________________________
10. Is your child presently being seen by a physician for a particular problem? ☐ Yes ☐ No
    IF YES,______________________________
11. Are there any areas in your child's mouth that cause pain or discomfort? ☐ Yes ☐ No
    Where?______________________________
12. Are there any questions regarding your child's dental health today? ☐ Yes ☐ No
    IF YES,______________________________

In the event insurance payments are not received, I understand that I am ultimately responsible for my balance. I understand that all responsibility for payments for dental services provided in this office to my child, are due and payable at the time services are rendered unless other arrangements have been made. In the event that payments are not received by the agreed dates, I understand that a 1 ½ % finance charge (18%) Apr may be added to my account.

I hereby authorize payment directly to the named doctor of the Group Insurance Benefits otherwise payable to me.

Signature **X** ______________________________ Date______________
Parent/Legal Guardian