

GARY A. OLEN, D.D.S., M.S., INC.
MICHAEL MAURER, D.D.S.
 PEDIATRIC AND ADOLESCENT DENTISTRY

Child's full name _____ Nickname _____
 Sex: F _____ M _____ child's date of birth _____ Age _____
 Address _____ Apt.# _____ City/State _____ Zip _____
 Home phone _____ Mother's cell _____ Father's cell _____
 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 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 hereby authorize the Pediatric Specialist of this practice to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of my child's dental needs.
2. I also 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.
3. 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.
4. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. I authorize the use of my social security number to file my child's dental claim.

Signature _____ Date _____