

Dayna L. Olstein, D.M.D.

Child's Name _____ Male/ Female Birth Date _____
First MI Last

Address _____ Town _____ Zip _____ Phone # _____

Parent's Names (Father) _____ Social Security # _____ Cell Phone _____
Father's Occupation _____ Employer _____ Work Phone _____
Father's Email _____

Parent's Names (Mother) _____ Social Security # _____
Mother's Occupation _____ Employer _____ Work Phone _____
Mother's Email _____

I Will Be Paying For My First Visit With _____ Cash _____ Check _____ Visa/Mastercard/AMEX

If Insured, Plan _____ Group # _____ Insured's Name/DOB _____

Whom May We Thank For Referring You? _____

Names and Ages of Other Children _____

Family Dentist _____ Child's Physician _____ Phone # _____

Grade and Name of School Child Attends _____

Name of Medications Taken Recently by Your Child (Including Vitamins) _____

Has Your Child Had Any Type of Allergic Reaction To Any Food, Medicine, or Other Substances? Please Describe Below:

Has Your Child Ever Been Hospitalized? _____ If Yes, Give Details _____

Does Your Child Have a Heart Murmur of Heart Defect? _____ If Yes, Give Details _____

If the Patient has had any of the following diseases or conditions, please check one(s):

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> AIDS or AIDS related complex |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> German Measles | <input type="checkbox"/> Asthma or Wheezing | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Hearing Difficulties | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bone and Joint Problems |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Speech Difficulties | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Growth Abnormalities |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Emotional Difficulties | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Serious Accidents | <input type="checkbox"/> Liver Disease or Hepatitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Removal of Tonsils or Adenoids | | <input type="checkbox"/> Cancer |

___ THERE IS NO HISTORY OF THESE PROBLEMS

Does Your Child Have Any of the Following? ___ Autism ___ ADD ___ PDD

What Is Your Main Reason For Bringing Your Child Today? _____

Is This The Child's First Dental Visit? ___ If Not, When Was The Last Visit and For What Reason? _____

Were Dental X-Ray Films Ever Taken Of Your Child? _____ By Whom? _____

Does Your Child Have Any of the Following Habits?

- | | | | |
|---|---|--|-----------------------------------|
| <input type="checkbox"/> Thumb Sucking | <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Pacifier |
| <input type="checkbox"/> Using the Bottle | <input type="checkbox"/> Tongue Thrusting | <input type="checkbox"/> Grinding of the Teeth | |

Has Your Child Ever Had Any Injury to the Face Of Teeth? _____

Has Your Child Ever Had An Unfavorable Reaction To Local OR General Anesthesia? _____

I give my consent for general dental treatment by Dayna L. Olstein, D.M.D. - Pediatric Dentist. Furthermore, the undersigned will be responsible for any fee incurred on the above child for dental treatment rendered.

X _____
Signature Date

Print Name Relationship to Child