Timothy R. Olinger, D.D.S.

PATIENT INFORMATION

Date _____

Patient's Name _____ Preferred Name _____

Age ____ Sex ___ Date of Birth _____ e-mail address _____

Patient's Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Father's Name _____ Social Security # _____

Address _____ Phone _____

Where Employed _____ Phone _____

Mother's Name _____ Social Security # _____

Address _____ Phone _____

Where Employed _____ Phone _____

With whom does patient live? _____

Phone number(s) for appointment confirmation _____

Other children in family / names and ages _____

Dental Insurance? ☐ No ☐ Yes: Subscriber Name _____ DOB of Subscriber _____

Child's Physician _____

Family Dentist _____

Whom may we thank for referring you to our office? _____

_____ _____
Signature Date

The undersigned persons represent that all the above statements are true and complete and hereby authorize verification of such information via credit reports. If my account should become delinquent, I will be responsible for all costs of collection including collection agency fees, attorney fees, and court costs. I understand that I will be charged a 1.5% per month or 18% per year finance charge if my balance goes beyond 60 days.

OVER →

CHILD'S NAME _____ **AGE** ____ **DATE** _____

MEDICAL HISTORY	**YES**	**NO**
Is child under care of a physician?	☐	☐
Name of physician _____		
Has child had surgery?	☐	☐
Is surgery contemplated?	☐	☐
Is child subject to profuse bleeding?	☐	☐
Is child subject to nervous disorders?	☐	☐
to fainting?	☐	☐
to dizziness?	☐	☐
Is child allergic to penicillin?	☐	☐
to other drugs?	☐	☐
Is child receiving any medication?	☐	☐
Has child had history of diabetes?	☐	☐
of heart trouble?	☐	☐
of asthma?	☐	☐
of kidney infection?	☐	☐
of rheumatic fever?	☐	☐
of toothache?	☐	☐
Has a family member ever had an unfavorable reaction to general or local anesthesia?	☐	☐

DENTAL HISTORY		
Is this the child's first visit to a dentist?	☐	☐
If not, how long has it been since the last visit?	☐	☐
Does child eat between meals?	☐	☐
Does child eat candy or other sweets?	☐	☐
Does child drink soda pop or chew gum?	☐	☐
Does child eat a well balanced diet?	☐	☐
Does child brush teeth upon arising?	☐	☐
When going to bed?	☐	☐
Right after eating meals?	☐	☐
After eating any food?	☐	☐
Do you have fluoridated water in the home?	☐	☐
Have child's teeth been treated with fluorides?	☐	☐
Have any cavities been noted in the past?	☐	☐
Have there been any injuries (falls, blows, chips, etc.) to child's teeth?	☐	☐
Has child had any unfavorable dental experience?	☐	☐

PARENT'S SIGNATURE _____

MEDICAL HISTORY UPDATE

_____

_____

_____

_____

_____