DAVID D. OFFUTT, D.D.S., INC.

PEDIATRIC DENTISTRY

PLEASE COMPLETE THIS FORM AND RETURN IT WHEN YOU BRING YOUR CHILD FOR THE FIRST VISIT. THESE QUESTIONS ARE OF GREAT VALUE IN AIDING US TO A BETTER UNDERSTANDING OF YOUR CHILD.

Child's Full Name ______ Preferred Name ______

Age ______ Birthday ______ Place of Birth ______

Attends what school ______ Grade ______

Name and age of brothers and sisters ______

Child's physician or pediatrician ______ Physician's Phone ______

Family Dentist ______

Who may we thank for referring you to us ______

Dental Insurance: Yes ___ No ___ Name of Insurance Co. ______

Purpose of visit ______

Name of child's pet and child's hobby ______ CHECK ONE Yes No

1. Is your child in good health? ______ ___ ___
2. Has your child had any history of epilepsy, blood disorders, cerebral palsy, heart trouble, allergies, diabetes, asthma, kidney or liver disorders (if yes, underline condition) for which he or she has received treatment or medicine? ______ ___ ___
3. Has your child had any unfavorable reaction or allergy to drugs, including antibiotics and local anesthetic solution? If so, Please specify. ______ ___ ___
4. Has your child ever been hospitalized? (If yes, when and why) ______ ___ ___
5. Is your child taking medicine? If so, what? ______ ___ ___
6. Has your child any history of thumbsucking, fingersucking, lip biting, nail biting? (If yes, underline condition) ___ ___
   Is this a currently active habit? ______ ___ ___
7. Is your child adopted? Yes ___ No ___ Has mother or father had a lot of decay? ______ ___ ___
8. In your family is there any history of any malocculusions, bad bites, missing or extra teeth? (underline and explain) ______ ___ ___
9. Has your child had any unfavorable experience in a dental or medical office? (If so, please underline which) ___ ___
10. Do you consider your child to be high strung or generally nervous or hyperactive? ______ ___ ___
11. Has your child had a toothache recently? Yes ___ No ___. Is your child in pain now? ______ ___ ___
12. Give date of last dental care? ______ Where? ______ ___ ___
13. Is your child (circle one): advanced in the learning process average A slow learner
14. Do father and mother and child live together? If no, please explain. ______ ___ ___
15. In case of emergency, contact (Specify someone who does not live in your household):
    Name ______ Address ______ Phone # ______
16. Remarks (Please use reverse side)

Dr.'s Remarks: ______

Father's Name ______ Mother's Name ______

Home Address ______ Zip ______ Phone ______
Street, City, State

Father Employed ______ Occupation ______
If self, please state business name

Business Address ______ Phone ______
Street, City, State

Mother Employed ______ Occupation ______

Business Address ______ Phone ______
Street, City, State

If you have previously completed this form for another child, please give that child's name ______

I hereby authorize the person to whom this history is made, or any credit bureau or other investigative agency employed by such person, to investigate any references herein listed or statements or other data obtained from me or from any other person pertaining to my credit and financial responsibility. I understand that accounts are to be settled in full each month unless arrangements are made.

The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental service and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, I will be responsible for any bill incurred on this child for dental treatment.

Father's Social Security # ______

Father's Driver License # ______

Mother's Social Security # ______

Mother's Driver License # ______

Signed ______
Parent or guardian

Date ______