YOUTH QUESTIONAIRE

OVERMEYER
FAMILY DENTAL

Child's Name: _____ Preferred name: _____

Age: ____ Date of Birth: _____ Social Security Number: _____

Address: _____ Apt #_____ City/State/Zip: _____

Mother's Name: _____ Fathers Name: _____

Mom's Cell Phone: _____ Dad's Cell Phone: _____

PCP Name: _____ PCP Phone: _____

Child's Interests or Hobbies: _____

Person Responsible for this Account: _____

By What Means were you referred to our office: Google Friend or Family Member,

Mailer Other Name: _____

Dental Insurance Information

Primary Insurance:

Ins. Co: _____

ID #: _____

Group Name: _____

Group Number: _____

Telephone: _____

Insured Name: _____

Insured DOB: _____

Insured SSN: _____

Circle if you child has had or currently has any of the following

__Measles __Mumps __Chicken Pox __Epilepsy

__Autism __Asthma __Anemia __Allergies

__Brain Injury __Skin Diseases __Heart Trouble

__Rheumatic Fever __Pneumonia __Tonsillitis

__Cleft Palate __Speech Problem __T.B.

__Bleeding Disorder __Liver Disorder

__Kidney Disorder __Ear Trouble __Eye Trouble

Is your child in general good health? _____

Does your child have any food allergies or sensitivities? _____ Please List: _____

Is your child allergic to any Medications? _____ Please List: _____

Is your Child currently taking any medications? _____ Please List: _____

Has your child ever been hospitalized? _____ Date/Reason? _____

Has your child ever been to the dentist for a complete exam and cleaning? _____

Has it been more than 6 months since your child has been to the dentist? _____ Date of last visit: _____

Has your child ever had a toothache or gum boil? _____

Is there a history of injury or falls involving the teeth? _____ Date/injury: _____

Did your child have a finger or thumb sucking habit after age two? _____

Has your child ever had fluoride applied to his/her teeth? _____ age: _____

Has your child ever has a local anesthetic? _____ Date: _____

Do you think your child will be a cooperative patient? _____

Any concerns about your child overall oral hygiene? _____

See Reverse for more info

YOUTH QUESTIONAIRE

Consent to treat child:

I, _____ (mother/ father/ guardian) of _____ (Child's name), hereby give my consent to Dr. Thomas G. Overmeyer, DDS, Dr. Jessica M. Overmeyer, DDS and/or the assistants and hygienists tp perform such treatments, services, medications and operations upon the teeth and oral structures as may be necessary to correct oral deficiency, abnormality and/or infection as presented on the treatment plan or as needed for emergency care.

_____ _____

Parent's Signature Date

_____

Print Name