



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: _____

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

Dental Insurance Information

Primary Insurance:

Ins. Co: _____
 ID #: _____
 Group Name: _____
 Group Number: _____
 Telephone: _____
 Insured Name: _____
 Insured DOB: _____
 Insured SSN: _____

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|--|---|--|------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Skin Diseases | <input type="checkbox"/> Heart Trouble | |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tonsillitis | |
| <input type="checkbox"/> Cleft Palate | <input type="checkbox"/> Speech Problem | <input type="checkbox"/> T.B. | |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Liver Disorder | | |
| <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Ear Trouble | <input type="checkbox"/> 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? _____

YOUTH QUESTIONNAIRE

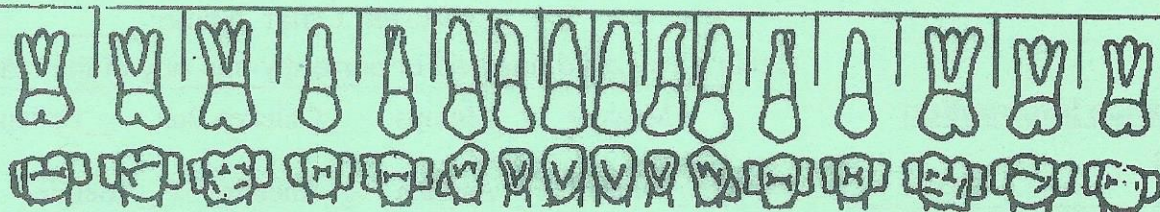

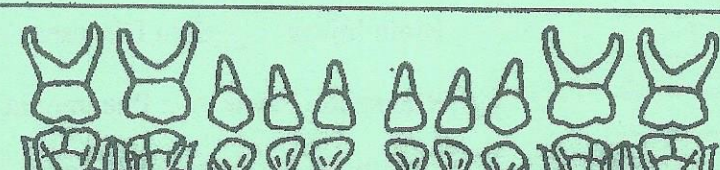
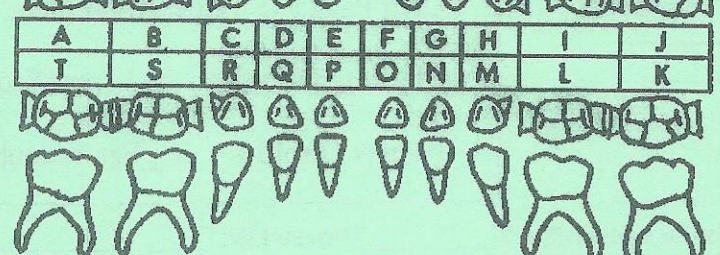
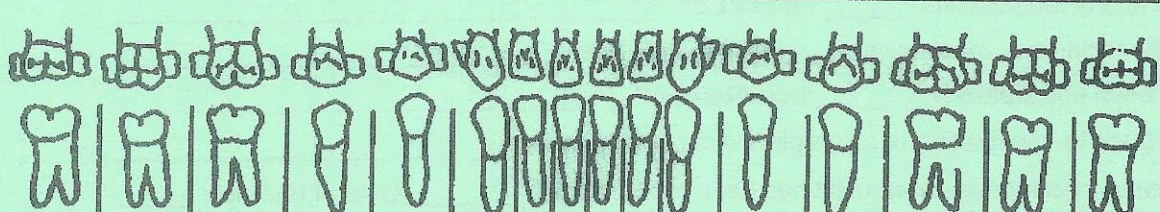
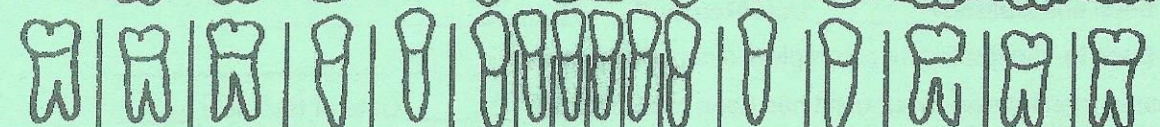
Consent to treat child:

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 to 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 _____

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