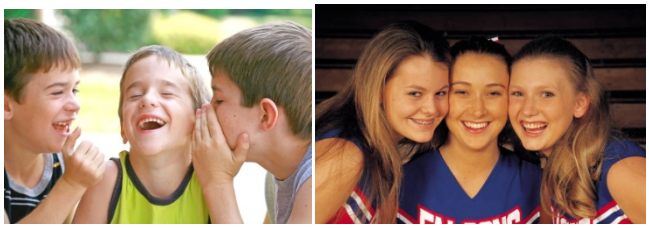
Thomas Dental Care* 12406 E. 86th St. N. Owasso, OK *74055*918-376-2700

Adolescent Form



Patient's name_____Nickname_____

Age____Sex____Date of Birth_____

Patient's address_____

Father's name_____Date of birth_____Social Security_____

His address_____Phone Number_____

Employer_____Phone Number_____Cell Phone_____

Mother's Name_____Date of birth_____Social Security_____

Her address_____Phone Number_____

Employer_____Phone Number_____Cell Phone_____

Phone number of confirmation of appointment_____Email for confirmation_____

With whom does the patient live?_____

Names of other children in the family_____

Dental Insurance Yes____ No____ Company_____Group_____

Name of person carrying the insurance_____Relation to patient_____

Authorization to pay benefits to pay Thomas Dental Care

Sign here_____

Child's physician_____

Name of and phone number of close relative to patient_____

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

Health History: Please answer yes to anything that pertains to your child.

	Yes	No	
• Is your child healthy?	___	___	
• Does your child have regular medical exams?	___	___	
• Is your child up to date on immunizations?	___	___	
• Is your child taking any medications?	___	___	If so, what?_____
• Has your child had a reaction to latex?	___	___	If so, what?_____
• ADD/ADHD?	___	___	
• Heart Conditions?	___	___	
• Congenital Heart Defects?	___	___	
• Lung problems?	___	___	
• Neurological problems?	___	___	
• Liver problems?	___	___	
• Kidney problems?	___	___	
• Epilepsy?	___	___	
• Diabetes	___	___	
• Cerebral Palsy	___	___	
• Bleeding Disorder	___	___	
• Sickle Cell Anemia	___	___	
• Hepatitis	___	___	
• Immune Disorder	___	___	
• Sleep Apnea/Snoring	___	___	
• Tuberculosis	___	___	
• Asthma	___	___	
• Allergies	___	___	
• Mentally Handicapped	___	___	
• Emotional Disorder	___	___	
• Nervous Disorder	___	___	
• Autism	___	___	
• Speech Disorder	___	___	
• Hearing Disorder	___	___	
• Vision Disorder	___	___	
• Other _____			
• Date of last physical_____			
• Significant Findings_____			

Is this your child's first dental visit?_____

If not, when was the last date of dental care?_____

Has your child had an unfavorable dental experience?_____

Purpose of this appointment?_____

Thank you your help. If there is any information that you think might be helpful in treating your child please feel free to comment.

_____

_____

I accept responsibility for this account should the named responsible party fail or insurance claim be denied. I also agree to the diagnostic procedures necessary to make a thorough evaluation of my child's dental needs. I understand that before any restorative treatment begins, I will be presented with a treatment plan to be mutually agreed upon by myself and Dr. Thomas. I also acknowledge that I received a copy of the privacy practices.

Signature_____ Date_____