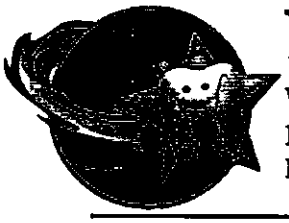


Waco Kids Dental
1121 Lake Air Drive
Waco, TX 76710
P: 254-772-8330
F: 254-772-8496

Aaron C. Blackwelder DDS
Board Certified Pediatric Dental Specialist

Tjel C. Olson DMD
General Dentistry Limited to Children

Information Sheet:

Today's Date: _____

Patient's Name: _____
FIRST MI LAST

Date of Birth: _____ Age: _____ **Male or Female**

Home Phone: (___) _____ Cell Phone: (___) _____

Address: _____ City: _____ Zip: _____

Email: _____ **TEXT** or **EMAIL** confirmation?

Patient's Medicaid (please circle) **MCNA/CHIPS, DENTAQUEST/CHIPS, TRADITIONAL** ID #_____

Childs School or Daycare that they attend: _____

Other siblings that seen in the office: _____

Who is accompanying the child today?

Name: _____ Relation: _____

Child resides with (circle one) **Both Parents, Mother, Father or Other** (list) _____

Father or Guardian's Information: (please circle) Father, Stepfather, Guardian

Name: _____ Date of Birth: _____

Phone# (___) _____ SS# _____ DL# _____

Email: _____ Employer: _____

Dental Insurance Information

Insurance Name: _____ Insurance Phone# _____

Group# _____ ID# _____

Mom or Guardian's Information: (please circle) Mother, Stepmother, Guardian

Name: _____ Date of Birth: _____

Phone# (___) _____ SS# _____ DL# _____

Email: _____ Employer: _____

Dental Insurance Information

Insurance Name: _____ Insurance Phone# _____

Group# _____ ID# _____

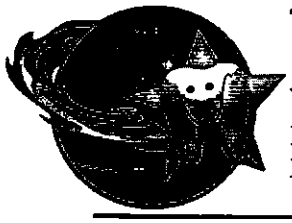
Relative or Friend not living with you:

Name: _____ Relationship to patient: _____

Phone# (___) _____

Whom may we thank for referring you? _____

Previous/Present Dentist: _____ Last Visit: _____



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Why did you bring your child to the dentist today?

_____

Is the child currently in pain? **YES** or **NO**

Does the child require antibiotics before dental treatment? **YES** or **NO**

Has the child ever had a serious/difficult problem with any dental work? **YES** or **NO**

Child's Medical Doctor_____ **Phone#**_____

List any Medications that the child is currently taking:

_____

List any drugs/things that the child is allergic to: _____

_____

Please circle if your child is allergic to: **LATEX, METALS, PLASTIC, OR RED DYE**

Has the child experienced the following medical problems?

ADD/ADHD	**Y** or **N**
Any Hospital Stays/ Operations?	**Y** or **N**
Artificial Bones/ Joints/ Valve	**Y** or **N**
Asthma	**Y** or **N**
Cancer	**Y** or **N**
Congenital Heart Defect	**Y** or **N**
Convulsions	**Y** or **N**
Diabetes	**Y** or **N**
Epilepsy	**Y or N**
Handicaps/ Disabilities	**Y** or **N**
Hearing Impairment	**Y** or **N**
Heart Murmur	**Y** or **N**
High Blood Pressure	**Y** or **N**
Autism Spectrum Disorder	**Y** or **N**
Kidney/ Liver Problems	**Y** or **N**
Mitral Valve Prolapse	**Y** or **N**
Sickle Cell Disease/ Traits	**Y** or **N**
Rheumatic Fever	**Y** or **N**
Tuberculosis	**Y** or **N**

Does/did the child experience any of the following?

Breast Fed	**Y** or **N**
Chewing on Objects	**Y** or **N**
Grinding Teeth	**Y** or **N**
Lip Sucking/ Biting	**Y** or **N**
Mouth Breather	**Y** or **N**
Nail Biting	**Y** or **N**
Nursing Bottle Habits	**Y** or **N**
Speech Problems	**Y** or **N**
Thumb/ Finger Sucking	**Y** or **N**
Used Pacifier	**Y** or **N**

Please discuss any serious medical problems the child has: _____

_____

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have provided is to the best of my knowledge. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian_____ **Date:**_____