



Greer Pediatric Dental Care
Dr. Mary Okuley

Patient Information

Child's Name _____ Name Called By: _____
Age _____ Birthday _____ Gender: M _____ F _____
Child's Home Address _____
STREET CITY STATE ZIP
Best Contact Phone Number _____
Name of School/Day Care _____
Brothers (Names and Ages) _____
Sisters (Names and Ages) _____
Whom may we thank for referring this patient? _____

Parent Information

Parent/Guardian Name _____ Relationship to Child _____
Address _____
STREET CITY STATE ZIP
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address _____
Social Security Number _____ - _____ - _____ Date of Birth _____
Employer _____ Occupation _____
Employer's Address _____
STREET CITY STATE ZIP
Parent/Guardian Name _____ Relationship to Child _____
Address _____
STREET CITY STATE ZIP
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address _____
Social Security Number _____ - _____ - _____ Date of Birth _____
Employer _____ Occupation _____
Employer's Address _____
STREET CITY STATE ZIP

Emergency Contact/Friend not living with you _____
Emergency Home Phone# _____ Emergency Work Number _____

Insurance Information

Insured's Name _____ Relationship to Patient _____
Insured's Employer _____ Insured's Date of Birth _____
Name of Insurance Company _____ Group Number _____
Insurance Company Address _____
STREET CITY STATE ZIP

I have received the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental plan benefit plan, unless Greer Pediatric Dental Care has a contractual agreement with my plan prohibiting all or portions of such charges. To the extent permitted by law, I authorize release of any information relating to claims filed.

Signature of Insured _____ Date _____

Medical History

Family physician or pediatrician _____

Date of last medical examination _____

Has your child had any of the following? Please indicate with a checkmark:

- Allergies to Anesthesia Childhood Illnesses Kidney/Liver Rheumatic Fever
- Allergies to Medicine/Drugs Contagious Disease Learning Disability Scarlet Fever
- Allergies to _____ Diabetes Malignancies Sinus Problems
- _____ Epilepsy/Seizures Measles Speech Disorder
- Anemia Hearing Disability Mumps Stroke
- Asthma Heart Problems Nervousness Typhoid Fever
- Autism Hepatitis Oral Herpes Tonsillitis
- Bleeding Disorder HIV virus Psychological Problem Tuberculosis

Does your child have any health problems that require active care of a physician? Yes No

Is your child presently taking any medications? Yes No

If yes, please list: _____

Has your child ever been hospitalized? Yes No

Reason: _____

Do you consider your child to be progressing normally? Yes No

If not, explain: _____

Dental History

Has your child complained about any dental problem? _____

Any injuries or surgeries to mouth, teeth, or head? Yes No

If yes, explain: _____

When did your child stop taking the bottle or sippy cup? _____

Do you assist your child with brushing? Yes No

How often? _____

Is dental floss used? Yes No

How often? _____

Is your home supplied by well water? Yes No

Please check box if your child has any of the following habits

- Thumb/Finger Sucking Mouth Breathing Pacifier Nail Biting Grinding

Other _____

Date of last dental visit _____ With whom _____

Explain briefly why you brought your child for dental care: _____

I hereby certify that all information is correct and true. Because the above-named child is a minor, it is necessary that a signed permission is obtained from a parent or legal guardian before any and/or all dental treatment can be commenced. I hereby grant such authorization, and shall accept responsibility for any and all fees incurred for such dental services. I understand that I am responsible for all charges whether or not covered by insurance.

Signature _____ Date _____

Relationship to Patient _____