Pediatric Dentistry
Pediatric, Adolescent, and Handicapped Dentistry

2930 South Pittsburg Ave., Tulsa, Oklahoma 74114 • Phone: (918) 742-9810

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD.
THANK YOU FOR COMPLETING IT IN FULL BEFORE YOUR CHILD'S FIRST VISIT.

Patient's name ______________________ Nickname ______________

Age________ Sex________ Race__________ Date of birth ______________

Patient's address ______________________ Home phone ______________
Street City State Zip

Father's name ______________ Date of birth __________ Social Security ______________

His address ______________________ Home phone ______________
Street City State Zip

Where employed ______________ Phone ______________ Cell phone ______________

Mother's name ______________ Date of birth __________ Social Security ______________

Her address ______________________ Home phone ______________
Street City State Zip

Where employed ______________ Phone ______________ Cell phone ______________

Phone number for confirmation of appointment ______________ E-mail for confirmation ______________

With whom does patient live? ______________

Names of other children in family ______________________

Dental insurance? ☐ Yes ☐ No Company ______________ Group #______________

Name of person carrying insurance ______________ Relationship to patient ______________

AUTHORIZATION TO PAY BENEFITS TO THE DENTIST: I hereby authorize direct payment of dental benefits to Morrow and Lai, D.D.S., PC.

(sign here) ______________________

Child's physician ______________ Family dentist ______________

Name and phone number of relative close to patient ______________________

Whom may we thank for referring you to our office: ☐ Doctor ☐ Parent ☐ Patient Name of person referring patient ______________

____
Address Street or RFD Town State Zip

HEALTH HISTORY

CHECK ANY OF THE FOLLOWING THAT MAY PERTAIN TO YOUR CHILD.

	YES	NO
Is your child in good health?	☐	☐
Does your child have regular medical exams?	☐	☐
Is your child up-to-date with immunizations?	☐	☐
Is your child presently taking medicine? If so, what? ______________	☐	☐
Has your child experienced any unfavorable reaction to medicine or latex? If so, what? ______________	☐	☐
Is your child presently undergoing medical treatment? If so, what? ______________	☐	☐
Premature Birth? If Yes, how many weeks? ______________	☐	☐
Has your child been hospitalized since birth?	☐	☐

☐ ADD / ADHD
☐ Heart Condition
☐ 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 ______________ Reason ______________________

Date of last physical ______________

Significant findings or medical diagnosis ______________________

Is this your child's first visit? ☐ Yes ☐ No

If not, date of last dental care ______________

Has your child had an unfavorable experience in a dental office? ☐ Yes ☐ No

Does your child have a toothache? ☐ Yes ☐ No

Purpose of this appointment ______________

Is your child currently a fingersucker? ☐ Yes ☐ No

Does your child currently use a pacifier? ☐ Yes ☐ No

Was your child bottle-fed? ☐ Yes ☐ No

Was your child breast-fed? ☐ Yes ☐ No

Age discontinued ______________

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment.

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I accept responsibility for this account should the named responsible party fail or insurance benefit 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 treatments begins, I will be presented with a treatment plan to be mutually agreed upon by myself, Dr. Morrow, Dr. Lai and/or Dr. Kitterman. I also acknowledge that I have received a copy of Notice of Privacy Practices.

Signature: ______________________ Date: ______________