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MINOR CHILD NEW PATIENT FORM

We would like to welcome you and your child to our office. Our goal is to make every child's visit **pleasant and educational**. Our practice is based on **preventive care**. We strive to teach good oral care that will enable your child to have **a beautiful smile that lasts a lifetime**

1 ABOUT YOUR CHILD

Name: _____
Last First Initial

Nickname: _____

Birth date: _____ Age: _____

SS# _____ Male Female

Special Interests, sports or hobbies: _____

Home Address: _____

Home Phone: _____

Email _____

Who may we thank for referring you? _____

2 ABOUT YOU (Parent or Guardian)

Your name: _____

SS# _____

Relationship to child? _____

Home Phone: _____

Address if different from child's: _____

Occupation: _____

Employer: _____

Employer's Address: _____

Work Phone: _____ Ext: _____

Cell Phone: _____

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # _____

Group # (Plan, Local or Policy #) _____

ID# _____

Insured's Name: _____

Relationship to patient: _____

Insured's Address: _____

Insured's birth date: _____

Insured's SS# _____

Insured's Employer: _____

Secondary Dental Insurance Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone# _____

Group# (Plan, Local or Policy #) _____

ID# _____

Insured's Name: _____

Relationship to patient: _____

Insured's birth date: _____

Insured's SS# _____

Insured's Employer: _____

4 DENTAL/MEDICAL HISTORY

Has your child been to the dentist before? No Yes

If yes, the approximate date of last visit? _____

Are there any dental problems that you are aware of at present? No Yes

If yes, please explain: _____

Does your child brush his / her teeth daily? No Yes

Please rate your child's oral health. Good Fair Poor

Is your child currently under the care of a physician? No Yes

Child's physician: _____

Their phone # _____

The approximate date of last visit? _____

Please rate your child's medical health. Good Fair Poor

Is your child allergic to any drugs? No Yes

If yes, please list: _____

Is your child taking any prescription / over-the-counter drugs?

No Yes If yes, please list _____

Does your child need to be premedicated before dental treatment? No Yes

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services my child may need.

Signature of parent or _____
Guardian:

_____ Date

! Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA

The Parent or Guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Has your child ever had any of the following medical conditions or problems?

- Y N Heart Murmur
- Y N Heart problems of any kind
- Y N Convulsions / Epilepsy
- Y N Cancer
- Y N Diabetes
- Y N Rheumatic Fever
- Y N HIV+ / AIDS
- Y N Hemophilia
- Y N Bleeding problems of any kind
- Y N Hearing Impairment
- Y N Hyperactive / ADD
- Y N Any operations
- Y N Any stays in hospital

Are there any other medical conditions or problems relating to your child? No Yes

If yes, please list: _____

In the event of an emergency, who should we contact?

Name: _____

Relationship: _____

Phone # _____

Phone #2 _____