Temple Kids Dental

2122 BIRDCREEK DR, TEMPLE, TX 76502
PHONE: 254.771.5701 FAX: 254.771.5770

MANUEL MARIEN, JR, D.D.S
Board Eligible Pediatric Dentist

Tjel C. Olson, DMD
General Dentistry Limited to Children

Aaron C. Blackwelder, DDS, MS
Board Certified Pediatric Dentist

Patient's Name: _____

FIRST MI LAST

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

Phone 1:_____**Phone 2**:_____

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 are seen in the office: _____

Who is accompanying the child today?

Name:_____Relation to child:_____

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

Father or Guardian's Information

Name:_____Date of Birth:_____**Relation**_____
Phone#_____SS#_____DL#_____
Email_____Employer_____

Dental Insurance Information
Insurance Name_____Insurance Phone #_____
Group#_____ID#_____

Mom or Guardian's Information

Name:_____Date of Birth:_____**Relation**_____
Phone#_____SS#_____DL#_____
Email_____Employer_____

Dental Insurance Information
Insurance Name_____Insurance Phone #_____
Group#_____ID#_____

****Relative or Friend not living with you:** **(please list someone)**

Name:_____Relationship to the patient:_____
Phone#_____

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

****How did you hear about Temple Kids Dental?** _____

Previous/Present Dentist:_____Last Visit:_____

****Our office staff will only release information about your child to the persons listed on the information sheet. ****

Why did you bring your child to the dentist today? _____

Is your child currently in pain? **YES OR NO**

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

Child's Physician/Medical Doctor: _____ Phone#:_____

Please Mark Each Item "Y" or "N" as It Relates to Your Child: (ALL MUST BE CIRCLED)

Y N Any Hospitalizations/ Surgeries If Yes, Please List: _____

Y N Heart Murmur/ Heart Problems

Y N Seasonal Allergies

Y N Asthma Date of Last Attack: _____

Y N ADD/ADHD

Y N Liver Problems

Y N Kidney Problems

Y N Cancer

Y N Convulsions/Epilepsy

Y N Diabetes

Y N Physical Impairment

Y N Mental Impairment/ Developmental Delay

Y N Autism

Y N Abnormal Bleeding

Y N Premature

Y N Sickle Cell Disease/Traits

Y N Hearing Impairment

Y N Tuberculosis

Y N Allergies to **LATEX**

Y N Allergies to **RED DYE**

Y N Allergies to **Metals**

Y N Allergies to **Plastics**

Please Mark Each Item "Y" or "N" as It Relates to Your Child:

Y N Chewing on Objects

Y N Grinding Teeth

Y N Lip Sucking /Biting

Y N Nail Biting

Y N Nursing Bottle Habits

Y N Speech Problems

Y N Thumb/ Finger Sucking

Y N Pacifier use

****PLEASE LIST ANY MEDICATIONS THE CHILD IS ALLERGIC TO** (please list below)

_____

Any other medical issues not listed above: _____

Please discuss any 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:_____

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