



# TIM FAGAN, DDS, MS, PLLC

SPECIALIZING IN PEDIATRIC DENTISTRY  
423 N. VAN BUREN • ENID, OKLAHOMA 73703  
Phone 580-233-0043 Fax 580-233-8571

Welcome 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. If you or your child have any questions, please feel free to ask. **PLEASE FILL OUT THIS FORM IN ITS ENTIRETY IN INK.**

## 1 ABOUT YOUR CHILD

Name \_\_\_\_\_  
Name your child prefers to be called \_\_\_\_\_  
Sex:  Male  Female  
Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_

## 3 ABOUT PAYMENT

Is your child covered by dental insurance? \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_  
SSN \_\_\_\_\_ DOB \_\_\_\_\_  
Home Phone Number \_\_\_\_\_  
Dental Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_ Effective Date \_\_\_\_\_  
Employer \_\_\_\_\_  
Method of payment for services not covered by insurance  
 Cash  Check  Credit Card

## 4 GENERAL INFORMATION

Reason for seeking care \_\_\_\_\_  
\_\_\_\_\_  
How did you find out about us? Who referred you to us?  
\_\_\_\_\_  
Has Dr. Fagan rendered treatment to any other family members? \_\_\_\_\_  
List names and relationship to patient \_\_\_\_\_  
\_\_\_\_\_

## 2 ABOUT YOU

Your Name \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
How long at this address? \_\_\_\_\_  
Home Phone Number \_\_\_\_\_ Cell \_\_\_\_\_  
Best Daytime Phone Number \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
SSN \_\_\_\_\_ DOB \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_ # Years \_\_\_\_\_  
Work Phone \_\_\_\_\_ OK to call? \_\_\_\_\_  
Spouse/Other Parent \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
How long at this address? \_\_\_\_\_  
Home Phone Number \_\_\_\_\_ Cell \_\_\_\_\_  
Best Daytime Phone Number \_\_\_\_\_  
SSN \_\_\_\_\_ DOB \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_ # Years \_\_\_\_\_  
Work Phone \_\_\_\_\_ OK to call? \_\_\_\_\_

### In case of emergency whom should we notify?

(Other than above) Name \_\_\_\_\_  
Best Daytime Phone Number \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Complete Address \_\_\_\_\_  
\_\_\_\_\_

## DENTAL HISTORY

5 Previous dentist's name and address \_\_\_\_\_  
Date of last examination or visit \_\_\_\_\_ Treatment provided \_\_\_\_\_  
Has your child experienced any unfavorable reactions from previous dental or medical care? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

### 6 Please circle any of the following your child has now or has had in the past:

Abscess or gum boil	Cold Sores or Fever Blisters	Pacifier sucking	Injury to front teeth/jaw/mouth/face
Mouth Breathing	Orthodontic Treatment	Bleeding gums	Clenching/grinding teeth
Finger/thumb sucking	TMJ/jaw problems	Fluoride Supplements	Other _____

**7** Breastfed until what age? \_\_\_\_\_ Bottled until what age? \_\_\_\_\_ Who brushes your child's teeth? \_\_\_\_\_  
 How many times daily? \_\_\_\_\_ Type of toothpaste used? \_\_\_\_\_ Is dental floss used? \_\_\_\_\_  
 Is there anything about the appearance of your child's teeth that you would like to discuss? if so, please explain \_\_\_\_\_

**8** Does your child have any health problems?  Yes  No  
 \*If yes, explain: \_\_\_\_\_  
 Is your child taking any medication or drugs (including non-prescription medications) at this time?  Yes  No  
 \*If yes, list: \_\_\_\_\_  
 Does your child have any allergies to drugs, medicines, latex rubber, or metals?  Yes  No  
 Please list: \_\_\_\_\_  
 Has your child ever been hospitalized, had surgery or an operation?  Yes  No  
 Procedure/Reason: \_\_\_\_\_

**9 Please circle any of the following that your child has now or has had in the past:**

- |                                       |                            |                              |
|---------------------------------------|----------------------------|------------------------------|
| Abnormal Bleeding or Blood Disorder   | Epilepsy                   | Nutritional Deficiency       |
| AIDS/Immunosuppressive Disorders      | Eye Problems               | Orthopedic Problems          |
| Anemia                                | Fainting                   | Pneumonia                    |
| Allergies                             | Hearing Loss               | Pregnancy                    |
| Artificial Joints, Implants or Valves | Heart Disease/Heart Murmur | Psychiatric Disorder         |
| Asthma                                | Hemophilia                 | Rheumatic Fever              |
| Autism                                | Hepatitis/Jaundice         | Scoliosis                    |
| Brain Injury                          | High or Low Blood Pressure | Sickle Cell Anemia           |
| Cancer/Tumors                         | Hyperactivity              | Spina Bifida                 |
| Cerebral Palsy                        | Kidney/Liver Problems      | Stomach Trouble/Ulcers       |
| Chemotherapy                          | Leukemia                   | Stroke                       |
| Cleft Lip/Palate                      | Lung Disease               | Syndrome _____               |
| Convulsions/Seizures                  | Mental Retardation         | Received a Blood Transfusion |
| Diabetes                              | Mumps                      | Tuberculosis                 |
| Emotional Problems                    | Muscle Disorders           | VD (Syphilis or Gonorrhea)   |
| Endocrine Disorders                   | Muscular Dystrophy         | Other _____                  |
- Comments \_\_\_\_\_

**10** Name of pediatrician or family physician \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 When was your child's last physical examination? \_\_\_\_\_  
 Is there any other information about your child's health that we should know? \_\_\_\_\_

**AUTHORITY TO TREAT**

I acknowledge that the above information is correct. I, being the parent, guardian or other person entitled to legal custody of the above mentioned minor child patient, hereby consent to and authorize the doctor to perform any and all forms of treatment, medication, therapy and patient management techniques that may be indicated in connection with the dental care of the patient and further authorize and consent that the doctor selects and uses such assistance as he deems necessary. I understand that the diagnosis of services needed and full explanation of the procedure(s) involved will be given by the doctor and/or his staff before treatment is rendered. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to pay for all services rendered by this office. If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balances. I understand that where appropriate, credit bureau reports may be obtained.

Signature \_\_\_\_\_

Date \_\_\_\_\_