Two (2) failed appointments will result in patient being placed on a one year waiting list. Please give 24 hours notice if you will be unable to keep a scheduled appointment.

417-582-5439 (KIDZ)
601 N. 21st Street / P.O. Box 1833 / Ozark, MO 65721

PATIENT INFORMATION:

Name: ____________________________, ______________________ _____
Last First MI

Preferred Name:___________________________________

Gender: M F **Date of Birth:** _____/_____/_____
MM DD YYYY

Medicaid/MO HealthNet #______________________________________

Mailing Address: ____

____

City: __________________________, **MO Zip:** _________

School your child attends? ____________________________________

How did you hear about the Center? ___________________________

RESPONSIBLE PARTY:

Name(s):____

Relationship to patient? _______________________________________

Home Phone: _____________________**Work Phone:** _______________

Cell Phone: ______________________**Other:** ___________________

MEDICAL INFORMATION:

Patient' s Physician Name and Phone#: ____

Has your child ever had any allergic reactions to?
Medications or drugs(Penicillin, Amoxicillin, Codeine, Sulfa, Ibuprofen, Aspirin, etc…)

____

Foods (peanuts, shellfish, milk products, etc ____________________________________

____

Other (Latex, etc…)____

Has your child ever had?

Nitrous Oxide_________ General Anesthesia__________ Sedation____________

Does your child currently, or has in the past, have any of the following?

_______ADHD
_______Allergies (Seasonal)
_______Anemia
_______Artificial Joints/Limbs/Valves
_______Asthma
_______Autism
_______AIDS/HIV
_______Behavioral Problems
_______Birth Defects
_______Blood Transfusion
_______Bruise Easily
_______Cancer/Tumors
_______Cold Sores
_______Cough
_______Diabetes
_______Downs Syndrome
_______Hemophilia/Abnormal Bleeding
_______Headaches
_______Heart Murmur***
_______Heart Defect
_______Hepatitis
_______Hives/Rashes
_______Kidney Disease
_______Learning Disorders
_______Leukemia
_______Liver Disease
_______Mental Disorders
_______Pain in the jaw
_______Pregnancy (currently)
_______Rheumatic Fever
_______Scarlet Fever
_______Seizures/Epilepsy
_______Shingles
_______Sinus Trouble
_______Speech/Hearing Trouble
_______Tuberculosis
_______Tobacco Use
_______Other________________

____

*****IF YOUR CHILD HAS A HEART MURMUR, WE WILL NEED A LETTER FROM THEIR PHYSICIAN BEFORE WE CAN SCHEDULE AN APPOINTMENT. (OUR FAX IS 417-485-5455.)**

CURRENT MEDICATIONS:____

____

____

DENTAL HISTORY:

How often does your child brush? ______ Once daily ______Twice daily ______________ Other

Who brushes your child's teeth? ____

Does your child use dental floss in cleaning his/her teeth? **Yes** **No**

Is your child taking a fluoride supplement? **Yes** **No**

Does your child grind his/her teeth? **Yes** **No**

Are any of your child's teeth currently causing pain? **Yes** **No**

Does your child drink soda? **Yes** **No** If so, how often?________________

Has your child experienced any unfavorable or unpleasant reaction from previous dental or medical care? **Yes** **No** If so, please explain__________________________________

____

____

____

Notice of Privacy Policies:

This facility has posted a copy of our Privacy Practices in the lobby and on our website. If you would like a copy, one will be provided at your request.

I have reviewed and understand the Privacy Practices of this office.

Date:__________________ **Signature:**____________________________________