108 N. Jefferson Street
Pandora, Ohio 45877
419-384-3278
www.putnam-dental.com

Putnam Family DENTAL

DR. C. BRAD POHL

15 E. Main Street
Leipsic, Ohio 45856
419-943-2278
www.putnam-dental.com

PATIENT INFORMATION

Name: _____
Last First MI

I preferred to be called: _____ ☐ Male ☐ Female

Birth date: _____/_____/_____ **SS#** _____-_____-_____

Address: _____

_____
City State Zip

Mobile: (_____) _____-_____ **Home**:(_____) _____-_____

Email:_____
interested in text or email reminders? Ask the business office

EMERGENCY Contact Name:

_____

Relation: _____

Phone: (_____) _____-_____

PRIMARY INSURANCE

Ins. Company: _____

Group # _____

Name of Insured: _____

I understand that information I have written about my child is correct to the best of my knowledge. I authorize the dental staff to perform any necessary dental services with my (or proxy) informed consent.

Signature:_____ Date:____/____/____

Printed Name:_____

Relation to Patient: _____

SECONDARY INSURANCE

Ins. Company: _____

Group # _____

Name of Insured: _____

PARENT or GUARDIAN'S INFORMATION

MOTHER'S INFORMATION

☐ Mother ☐ Step Mother ☐ Guardian

Name: _____
Last First MI

Birth date: _____/_____/_____ SS# _____-_____-_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Address: _____

_____ ☐ Same as Child's
City State Zip

Home:(_____) ____-_____ **Mobile**:(_____) ____-_____

Email: _____

Employer: _____

☐ Yes ☐ No: I am the subscriber for my child's dental ins.

FATHER'S INFORMATION

☐ Father ☐ Step Father ☐ Guardian

Name: _____
Last First MI

Birth date: _____/_____/_____ SS# _____-_____-_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Address: _____

_____ ☐ Same as Child's
City State Zip

Home:(_____) ____-_____ **Mobile**:(_____) ____-_____

Email: _____

Employer: _____

☐ Yes ☐ No: I am the subscriber for my child's dental ins.

List all responsible parents/guardians for the minor:

Name: _____ Relation: _____ Is a patient? ☐Yes ☐No ☐Unsure

Name: _____ Relation: _____ Is a patient? ☐Yes ☐No ☐Unsure

MEDICAL HISTORY

Child's current physical health is: ☐ Good ☐ Fair ☐ Poor

Primary Care Physician: _____

Is the child taking prescription or over/counter drugs?
☐No ☐Yes

Please list: _____

_____

Medical & Dental Allergies: ☐No ☐Yes

_____

Recent Surgical History: ☐No ☐Yes

_____

Does your physician require a pre-medication for dental appointments? ☐ No ☐ Yes

Does your child Smoke: ☐ No ☐ Yes Use Tobacco? ☐ No ☐ Yes

Females: Is your child using prescription birth control? ☐ No ☐ Yes
Is your child pregnant? ☐ No ☐ Yes

DENTAL HISTORY

Date of last dental visit: _____

Rate your child's smile:
1 2 3 4 5 6 7 8 9 10

Your child's current dental health is:
☐ Good ☐ Fair ☐ Poor

Do they brush daily? ☐ No ☐ Yes

Type of bristles? ☐ Hard ☐ Med ☐ Soft

Do they floss daily? ☐ No ☐ Yes

Do their gums bleed? ☐ No ☐ Yes

Sensitive to Hot/Cold? ☐ No ☐ Yes

Is your child having any specific dental problems? ☐ No ☐ Yes

Explain: _____

_____

Please circle any medical condition / disease applicable:

ADD / ADHD

AIDS / HIV

Alcohol / Drug Abuse

Anemia

Artificial Bones / Joints

Asthma / Difficulty Breathing

Autism / Sensory

Blood Transfusion

Cancer / Radiation

Congenital Heart Defect

Diabetes

Epilepsy / Seizures

Fever Blisters / Herpes

Frequent Headaches

Hay Fever / Sinus Problems

Hearing Impairment

Heart Murmur

Heart Surgery

Hepatitis

High/Low Blood Pressure

Kidney Problems / Disease

Liver Disease

Lupus / Anemia

Anxiety / Depression or other Psychiatric Issues

Rheumatic / Scarlet Fever

Sickle Cell Disease / Traits

Thyroid Problems

Tuberculosis (TB)

Ulcers / Colitis

Other: _____

_____

_____

I understand that information I have written for my child is correct to the best of my knowledge. I authorize the dental staff to perform any necessary dental services with my informed consent.

Signature _____ Date ____/____/____

Printed name of Parent/Guardian _____