CASLER
DENTAL GROUP
6911 South 66th East Avenue - Suite 300
Tulsa, Oklahoma 74133-1748
(918) 477-7677

MINOR'S HEALTH HISTORY AND INFORMATION

(Please Print Clearly) Minor's SSN_____

Minor's Name _____ Age _____ Birth Date _____/_____/_____
Last First Nickname

Home Address _____ Res. Phone _____

Father's Information:
Father's Name _____
Birth Date _____ SSN _____
Place of Employment _____
Work Ph. _____ Cell Ph. _____
E-mail _____

Mother's Information
Mothers's Name _____
Birth Date _____ SSN _____
Place of Employment _____
Work Ph. _____ Cell Ph. _____
E-mail _____

Primary Dental Ins. Co. _____ Policy Holders Name _____
ID No. _____ Group No. _____
Secondary Dental Ins.Co. _____ Policy Holders Name _____
ID No. _____ Group No. _____

How long since child's last dental visit? _____ Does Child have x-rays available? _____
Child brushing regularly? ❑ Yes ❑ No Flossing regularly? ❑ Yes ❑ No
Any specific concerns to discuss with Dr. Casler today? _____
Whom may we thank for referring patient to our office? _____

MEDICAL HISTORY

Child allergic to any medications or substances? ❑ Yes ❑ No If so, to what? _____
Child's Physician _____ Child in good health now? _____
Child under a physician's care now? _____ If so, for what? _____
Child ever been hospitalized? _____ If so, for what? _____
Child taking any medications now? ❑ Yes ❑ No If so, please list _____

Does child have or has child had any of the following?

❑ Yes ❑ No Hepatitis	❑ Yes ❑ No Chemotherapy	❑ Yes ❑ No Stroke
❑ Yes ❑ No Rheumatic Heart Fever	❑ Yes ❑ No Excessive Bleeding	❑ Yes ❑ No Tuberculosis
❑ Yes ❑ No Mitral Valve Prolapse	❑ Yes ❑ No Anemia	❑ Yes ❑ No Recent Weight Loss
❑ Yes ❑ No Heart Murmur	❑ Yes ❑ No Arthritis	❑ Yes ❑ No Mentally Disabled
❑ Yes ❑ No Any Heart Problems	❑ Yes ❑ No Asthma	❑ Yes ❑ No Physically Disabled
❑ Yes ❑ No High Blood Pressure	❑ Yes ❑ No Seizers	❑ Yes ❑ No Hearing Impairment
❑ Yes ❑ No Fainting Spells	❑ Yes ❑ No Epilepsy	❑ Yes ❑ No Radiation Treatment
❑ Yes ❑ No Ulcers	❑ Yes ❑ No Diabetes	❑ Yes ❑ No Sinus Problems
❑ Yes ❑ No ADD/ADHD	❑ Yes ❑ No Depression/Anxiety	❑ Yes ❑ No Seasonal Allergies

❑ Yes ❑ No Other _____ List any communicable diseases _____
❑ Yes ❑ No Child ever tested positive for the AIDS Virus?

X _____ Date _____/_____/_____
Parent or Guardian Signature