

**CHILDREN'S DENTAL CENTER  
OLGA L ORTUZAR, DDS, MS, PS & ASSOCIATES  
PEDIATRIC DENTISTRY**

**PATIENT INFORMATION**

Childs Last Name	First	Middle	Nickname	Sex M F	Date of Birth	Age
Child's Address (Street)		City	State		Zip Code	Phone
Child's School/Preschool					Grade	

Parent's Full Name	Relationship to Child	Parent's Full Name	Relationship to Child
Address		Address	
City	State	Zip	
Home Phone	Work Phone	Home Phone	Work Phone
Occupation		Occupation	
Name of Employer		Name of Employer	
Years with this Employer		Years with this Employer	
Dental Insurance Company		Dental Insurance Company	
Social Security Number		Social Security Number	
Group #	Date of Birth	Group #	Date of Birth
Driver's License Number		Driver's License Number	

Do both Parents and Child all live together? (If No, Please explain)		
If Parents cannot be reached, Friend or Relative to Notify should an emergency arise. Name		Phone
Relationship		
Has any member of your family been a patient in this office <input type="checkbox"/> YES <input type="checkbox"/> NO	Name of Siblings	Is patient covered by Public Assistance Coupons? <input type="checkbox"/> YES <input type="checkbox"/> NO
Family's General Dentist	Date of Child's last exam and cleaning and name of Dentist	

Consent and Assignment for the Treatment of a Minor

The undersigned hereby authorizes Dr. Olga L. Ortuzar and Associates (Children's Dental Center) to perform the examination and, after explanation, the necessary dental services and those methods she deems appropriate in her professional judgment for the care of the above-named child. This authorization includes the release of my child's medical records if deemed necessary for the proper care of my child. I further authorize that my insurance benefits be paid directly to the dentist and I understand that I am financially responsible to the dentist for all the charges not covered by my insurance. The consent shall remain in full force and effect until cancelled by either party.

Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Relationship to Child

**PLEASE COMPLETE BOTH SIDES**

