Small World Pediatric Dentistry, P.C.
Andrew Guthrie, D.D.S, M.S.D.
3616 N.W. 50th St.
Oklahoma City, OK 73112
(405)946-0686

Patient Name: (Last)________________(First)________________(Preferred)____________

Gender: Male _______ Female _______ Birth Date: _____________________

Phone: (Immediate Contact) ____

Address: ____

Has your child had any history or difficulty with any of the following? (Please Circle)

ADHD	AIDS/HIV	Anemia
Asperger's Syndrome	Asthma	Autism
Bladder Problems	Blood Disease	Brain/Head Injuries
Cancer	Chemotherapy	Cerebral Palsy
Chicken Pox	Convulsions/Seizures	Deaf
Developmental Disorder	Diabetes	Down Syndrome
Epilepsy	Excessive Bleeding	Fainting
Glaucoma	G-Tube Fed	Hearing Problems
Heart Murmur	Heart Problems	Hepatitis
Kidney Disease	Liver Disease	Measles
Mononucleosis	Mumps	Non-Verbal
Radiation Treatment	Respiratory Problems	Rheumatic Fever
SBE/Endocarditis	Sensory Integration	Sinus Problems

Stomach/Digestive Problems	Thyroid Disease	Tuberculosis
Tumors	Vision Problems	Wheelchair
Other		

IS YOUR CHILD: (Please Circle)

Taking Any Medications

Allergic to Substances/Medications

Any Surgery/Hospitalizations

Please List all medications and/or drugs the patient is currently taking:

____
____
____

Please List all medications/drugs and all the substances the patient is ALLERGIC to:

____
____
____

Has the patient ever been hospitalized/had surgery? (Please list date)

____
____
____

OTHER:____
____

I agree to notify the dentist if any change in my child's health status should occur.

Signature of parent or legal guardian ________________________________ Date __________

Please fax to 405-946-0687