

MHGT'F GP VCN'URGEKCNKV-PEDIATRIC DENTISTRY

www.happysmile4you.com
408-900-7252 (Phone) 408-900-7263 (Fax)
kiferpedo@gmail.com

PATIENT INFORMATION AND MEDICAL HISTORY FORM

Date: _____

Patient's Name: _____ Age: _____ Sex: _____

Date of Birth ____/____/____ Grade: _____ School: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Patient's Social Security Number: ____-____-____

Guardian's email: _____

PARENT INFORMATION

Parent/Legal Guardian 1: _____ Relation to patient: _____

Employer: _____ Phone: _____ Date of Birth ____/____/____

Parent/Legal Guardian 2: _____ Relation to patient: _____

Employer: _____ Phone: _____ Date of Birth ____/____/____

____ Who has legal custody of patient? _____ Dental Insurance: Yes No

Person responsible for payment of account _____ SSN#/Member ID#: _____

Marital Status of Parents: Married / Separated / Divorced / Other: _____

WHOM MAY WE THANK FOR REFERRING YOU TO US?

Name: _____

- From a Friend www.happysmile4you.com Phone Book Dental Office Pediatrician/Doctor
- Other

EMERGENCY CONTACT (other than parents)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

HEALTH PROVIDER

Child's Physician/Pediatrician: _____ Phone#: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

DENTAL HISTORY

What is the reason for your child's dental visit? _____

Yes No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) _____

Name of previous dentist: _____ Phone: _____

Yes No Has your child experienced any unfavorable reaction from previous dental care?

Explain _____

Yes No Does your child suck a finger, thumb, or pacifier? Which one? _____

Yes No Does your child go to bed with a bottle or sippy cup? If so, what is in it? _____

Yes No Does your child snack frequently? What are their favorite snack foods? _____

Yes No Has your child had local anesthetic? Were there any problems? _____

Yes No Has your child been sedated for dental treatment? Were there any problems? _____

Yes No Have your child's teeth ever been injured? Which teeth: _____

Dental treatment for trauma: _____

Yes No Has your child or anyone in your immediate family ever had a cavity? If so, who and when? _____

Please check if your child is having problems with any of the following:

- Cavities Orthodontics Sensitive Teeth Mouth Breathing
- Trauma Gum Infections Color of Teeth Other
- Toothaches Jaw Sounds Grinding of Teeth

Explanations and Comments: _____

FLUORIDE HISTORY

- Yes No Is your home water supply fluoridated?
- Yes No Does your child use a fluoride toothpaste?
- Yes No Do you give your child any other forms of fluoride? What? _____
- Yes No Does your child participate in a school fluoride rinse program? _____

MEDICAL HISTORY

- Yes No Is your child in good health? Date of last physical exam _____
- Yes No Does your child have a health problem? _____
- Yes No Allergies (Please List) _____
- Yes No Is your child taking any medications at this time? Please give medication, dose, and reason: _____
- Yes No Are your child's immunizations current?
- Yes No Have you ever been told that your child needs to take *antibiotics before dental treatment*?
- Yes No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain: _____
- Yes No Were there any difficulties at birth? _____

Do you consider your child to be: advanced in learning progressing normally slow learner

Please check if your child has been treated for any of the following:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Bleeding/transfusions | <input type="checkbox"/> Asthma/breathing |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood dyscrasias | <input type="checkbox"/> Tonsil/adenoid problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Liver/GI disease | <input type="checkbox"/> Sickle cell disease/trait | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV+/AIDS |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental delays |
| <input type="checkbox"/> Speech/hearing | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Physical delays |
| <input type="checkbox"/> Eyesight | <input type="checkbox"/> Congenital birth defects | <input type="checkbox"/> Personality/social | <input type="checkbox"/> Cancer/tumors |
| <input type="checkbox"/> Recurrent headaches | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Adverse drug reactions | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Significant injuries | <input type="checkbox"/> Endocrine/growth | <input type="checkbox"/> Autism | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Spina bifida | <input type="checkbox"/> Snoring | <input type="checkbox"/> Abuse |

Other: _____

If any boxes checked, please describe further: _____

I certify that I have read and understand the above information on both sides of this form to the best of my knowledge. All questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I also understand it is very important to report any changes in my child's medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain any additional information from my child's physician regarding his/her medical history needed to provide the best dental treatment possible.

I give consent for Dr. Ng and staffs to perform a dental examination, dental prophylaxis (cleaning), fluoride treatment and take x-rays on my child.

PERSON COMPLETING THIS FORM: Signature _____ Date _____

Relationship to Patient: _____