

PEDIATRIC DENTISTRY

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Child's/Teen's Personal History

Today's Date _____

First Name: _____ Last Name: _____

Birthdate: _____ Age: _____ Sex: _____

City/State of Birth: _____ Reason for today's visit: _____

Names of siblings _____

Who may we thank for referring you to our office? _____

Parent #1- Mother / Father / Guardian (please circle)

First Name: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____

Home address: (street) _____

(city) _____ (state) _____ (zip) _____

Telephone #: _____ cell #: _____

Email address _____

Name of Employer/Union: _____ work #: _____

Dental Insurance Co. : _____ Ins. Co. 800 #: _____

Parent #2- Mother / Father / Guardian (please circle)

First Name : _____ Last Name: _____

Date of Birth: _____ Social Security Number : _____

Home address: (street) _____

(city) _____ (state) _____ (zip) _____

Telephone #: _____ cell #: _____

Email address _____

Name of Employer/Union: _____ work #: _____

Dental Insurance Co. : _____ Ins. Co. 800 # : _____

Other Dental Ins. Co. Name : _____

Ins. Co. 800 #: _____

Name of Policy Holder : _____ Relationship to child: _____

Social Sec. # /ID: _____ Date of Birth : _____

With whom does your child live, and who has legal custody? (for insurance only) _____

In case of emergency, who may we contact, other than a parent?

Name: _____ Phone #: _____

MEDICAL HISTORY

These questions are of great value in aiding us in the treatment and better understanding of your child/teen, medically, dentally and socially. **Please circle YES or NO and circle or explain as needed.**

1. Date of child's last **MEDICAL** examination: _____
2. Name of child's Doctor/Pediatrician: _____
3. Pediatrician's address and phone number: _____
4. Is your child taking any medicines now? (eg. vitamins, cough/cold meds, birth control pills, behavioral meds, herbs, antibiotics, allergy, diet pills, etc.....) YES NO
Please explain: _____
5. Has your child ever been hospitalized or had any operations? YES NO
Please explain: _____
6. Has your child received general anesthesia or sedation? YES NO
Please explain: _____
7. Are your child's immunizations up to date? YES NO
8. Has your child become sick from, shown an allergy to or been told not to take:
(circle yes or no & explain any yes answers)
 - 8a. Penicillin, Amoxicillin, or other antibiotics YES NO
 - 8b. Foods YES NO
 - 8c. Aspirin, codeine or other pain medication YES NO
 - 8d. Lidocaine, or other anesthetics YES NO
 - 8e. Latex rubber YES NO
 - 8f. Other medicines YES NO
9. Please explain any reaction to any of the above items: _____

10. Is your child adopted or a foster child? YES NO
11. Was this child's mother using alcohol or other drugs during pregnancy? YES NO
12. Has your child ever been abused or molested? (this may affect behavior) YES NO
13. Has your child been exposed to the AIDS virus or is HIV positive? YES NO
14. Has your child ever had a blood transfusion? YES NO
15. Is there a family history of malignant hyperthermia? YES NO
16. **DOES YOUR CHILD HAVE CURRENTLY OR HAS EVER HAD:** (circle yes or no and circle which disease)
 - 16a. Heart disease, heart defect, heart murmur YES NO
 - 16b. Rheumatic fever , high blood pressure YES NO
 - 16c. Fainting spells, convulsions, epilepsy, cerebral palsy YES NO
 - 16d. Developmental delay, severe Autism, retardation YES NO
 - 16e. Lung disease, asthma, bronchitis, TB YES NO
 - 16f. Liver disease, jaundice, hepatitis YES NO
 - 16g. Diabetes Type I or II, Kidney disease YES NO
 - 16h. Blood disorders, hemophilia, sickle cell, anemia YES NO
 - 16i. Arthritis, cancer, leukemia, tumors YES NO
 - 16j. Measles, mumps, whooping cough, chickenpox YES NO
 - 16k. Frequent sore throats, headaches, ear aches, tonsillitis YES NO
 - 16l. Eye problems, blindness, cataracts YES NO
 - 16m. Hearing problems, deafness YES NO

- 16n. Hyperactivity, learning differences, AspergersYES NO
- 16o. Hormonal , endocrine or digestive problems.....YES NO
- 16p. Muscular or skeletal problems.....YES NO
- 16q. Viral or bacterial infectionsYES NO
- 16r. Congenital birth defects, cleft lip ,cleft palateYES NO
- 16s. Is your teenager sexually active or pregnant?..... YES NO

DENTAL HISTORY

- 1. Is your child currently breast or bottle feed? (circle which).....YES NO
- 2. Does your child suck their finger(s), thumb, pacifier, blanket, etc. (circle which).....YES NO
- If yes, please explain _____
- 3. When during the day or night are your child’s teeth brushed/flossed?_____
- Who does the brushing/flossing? _____(circle one or both if you brush and /or floss)
- 4. Is your child using fluoride ? (toothpaste, rinse, drops, pills)(circle which)YES NO
- 5. Has there ever been any problems with your child’s jaw joint (TMJ)?.....YES NO
- 6. Has your child been to see a dentist before?YES NO
- 7. What was the date of the last dental visit? _____
- 8. Name of previous dentist _____
- 9. How was your child’s past dental experience? _____
- _____
- 10. Please describe your child’s temperament or personality: _____
- _____
- 11. Is there anything else we should know about your child to better understand and treat them?
- _____
- _____

I certify that I have read and understood the above medical and dental questions. I will not hold Dr. Allen or any member of her staff responsible for any errors or omissions I may have made in the completion of this form.

Signature: _____ Relation to child : _____

Print name : _____

I hereby consent to the performance of Dental Services upon this patient. Services include exam, cleaning, fluoride, anesthetics, sedatives, fillings, extractions or necessary x-rays as may be deemed necessary and advisable by the Doctor. Any and all necessary treatment will be discussed with the parent or guardian before beginning. **I ALSO AGREE TO BE FINANCIALLY RESPONSIBLE FOR ANY TREATMENT, WORK PERFORMED OR MISSED APPOINTMENTS. PAYMENT IS EXPECTED AT THE TIME OF SERVICE.** If I have dental insurance to help pay for my child’s dental care, I agree to be financially responsible for any portion my insurance company does not cover. I also agree to pay finance charges on any balance due over ninety (90) days. I also agree to reimburse the dentist for reasonable attorney fees and costs incurred in the collection of my delinquent account, if necessary.

Signature of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian # 2 (if divorced) _____ Date: _____