PEDODONTIC PATIENT INFORMATION

Please assist us by answering all of the following questions. This confidential information is important for our records in evaluating and treating your child.

PATIENT HISTORY RECORD Date

Child's Name _____ ☐ Male ☐ Female
LAST FIRST INITIAL NICKNAME

Age Patient's Birthday School Grade

Reason for this visit

Referred to our office by Telephone ( )

MEDICAL HISTORY (Please circle **'Y' or "Yes", 'N' or "No"** - answer all conditions):

Child's physician Telephone ( )
CITY

Date last saw physician
MONTH / YEAR

1. Is your child presently under the care of a physician for any medical problem or condition? ..... Yes No
   What?
2. Is your child currently taking any medication ..... Yes No
   What?
3. Does your child have/had any of the following:

Y N Diabetes	Y N Murmurs	Y N Seizures	Y N Heart trouble	Y N Liver involvement	Y N Blood disorders	Y N Acquired Immune
Y N Asthma	Y N Allergies	Y N Convulsions	Y N Drug sensitivity	Y N Rheumatic fever	Y N HIV related complex	Deficiency Syndrome
Y N Epilepsy	Y N Hepatitis	Y N Brain injury	Y N Kidney involvement	Y N Bleeding problems	Y N Other:	

4. Has your child ever been hospitalized or had surgery ..... Yes No
   For what? When?
5. Is your child emotionally disturbed, retarded, handicapped, or have any learning disabilities ..... Yes No
6. Is there any other medical history or problem you feel should be brought to the doctor's attention ..... Yes No
   What?

DENTAL HISTORY

1. Is this your child's first dental visit ..... Yes No
   Previous dentist Telephone ( )
   CITY DATE OF LAST VISIT
   Why are you changing dentists?
2. Has your child had an unfavorable experience in a previous dental (or medical) office ..... Yes No
3. Have there been any injuries to your child's teeth or jaws — falls, blows, chips, etc. ..... Yes No
4. Does your child receive fluoride vitamins, tablets, water, etc. ..... Yes No
5. Has your child been seen by an orthodontist ..... Yes No
6. Name of family dentist Telephone ( )
   CITY

FAMILY RECORD

Residence Telephone ( )
ADDRESS CITY ZIP

Father's full name
DATE OF BIRTH SOCIAL SECURITY NUMBER

Address *(if different)*
CITY ZIP

Occupation Employed by

Business address Telephone ( )
CITY ZIP

Mother's full name
DATE OF BIRTH SOCIAL SECURITY NUMBER

Address *(if different)*
CITY ZIP

Occupation Employed by

Business address Telephone ( )
CITY ZIP

Please list the first names of all brothers and sisters, their ages and schools:

Has any member of your family been a patient in this office before ..... Yes No
If yes, name and when:

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

1. Is your child covered by a dental insurance plan ..... Yes No
   Name of insurance company (primary insurance)

INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN GROUP NO PLAN NO NAME OF UNION LOCAL

2. Is your child eligible for state/county aid? Y N State Aid No.
3. If family is not living together, person to be responsible for child's account

I HEREBY AUTHORIZE THE DENTIST(S) IN CHARGE OF THE CARE OF MY ABOVE NAMED CHILD TO PERFORM ANY AND ALL TREATMENT AND CONSENT TO SUCH METHODS, DRUGS AND AGENTS AS MAY BE INDICATED IN CONNECTION WITH HIS/HER DENTAL CARE. THIS CONSENT SHALL REMAIN IN EFFECT UNTIL CANCELLED.

Signature Relationship to the child Date

***PLEASE NOTE:** Payment is expected for service rendered at the time of the first visit. Financial arrangements for subsequent treatments may be made following the diagnosis.*

DENRAM 226 West Main Avenue, Monrovia, CA 91016-3392 FAX 626.357.6616 ☎ 626.359.8276 denram@denram.com www.denram.com