



13768 Roswell Ave, Suite 221, Chino, CA 91710 Tel: (909) 548-6828 Fax: (909) 548-6893

YOUR CHILD'S INFORMATION (ALL INFORMATION IS CONFIDENTIAL)

Date _____ Child's Name _____ Nickname _____

Birthdate _____ Age _____ Child's School _____

Address _____

Phone _____ Child lives with both parents mother father other _____

Father's Name _____ Cell Phone _____

Mother's Name _____ Cell Phone _____

Emergency Contact (other than parents) Name _____ Phone _____

Name & Age of Brothers/Sisters _____

Who referred you to our office/How did you hear of our office?

MEDICAL HISTORY

Physician's Name _____ City _____ Phone _____

Last physical Checkup _____ Has patient ever been hospitalized? _____

When? _____ Reason _____

Is your child under medical care at the present? If yes, please state :

Does your child have any of the following?

- | | | | | |
|--------------------------------------|---|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Unusual Bleeding | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Conditions | <input type="checkbox"/> Autism | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Developmentally Delayed | |
| <input type="checkbox"/> OTHER | Please give details | | | |

Medications taken

List all allergies to medications, food, substances, latex etc.

DENTAL HISTORY

Reason for visit (toothache, checkup, bad experience, emergency)

Is this the patient's first visit to the dentist? YES NO, If not, please provide previous dentist's name, address, telephone and what was done

Has your child : Put to bed with bottle injury to mouth or teeth oral habits (thumb, pacifier, etc)

