DENTISTRY FOR Little Folks

PATIENT INFORMATION
HEALTH HISTORY

Demographic Information

Patient_____Nickname_____ Date_____
Birthday_____ Age_____ Sex: _____ Male _____ Female
Home Address _____
street city zip code
Mother/Guardian_____Home #_____ Cell #_____
Employer_____ Work # _____
Father/Guardian_____ Home #_____ Cell #_____
Employer_____ Work # _____

Who has legal custody of patient?_____ Dental Insurance:___ Yes____No
Dental Insurance Company_____ Group#_____
Person responsible for payment of account_____ SS#_____DOB_____
Dental Insurance telephone # _____
Whom may we thank for referring you to us? _____
What is the reason for your child's dental visit? _____

Health History

Yes___No___ Is your child in good health? Name of child's physician_____
Date of last physical exam_____
Yes___No___ Has your child ever had a health problem?_____
Yes___No___ Has your child ever been hospitalized? Please give reason and dates :
_____
Yes___No___ Is your child allergic to anything? _____
Yes___No___ Is your child currently taking any medications? Please give medication, dose, and reason for taking:
_____
_____
Yes___No___ Were there any problems at birth? _____

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

Heart disease_____	Bleeding/transfusions_____	Asthma/breathing_____	Blood disorders___
Liver/GI disease____	Anemia _____	AIDS/HIV _____	Diabetes _____
Kidney disease _____	Rheumatic fever _____	Hepatitis _____	Mental delays ____
Speech/hearing_____	Seizures _____	Cleft lip/palate _____	Physical delays ____
Cerebral palsy_____	Congenital birth defects____	Personality/social _____	Autism _____
Cancer/tumors____	Recurrent headaches_____	Frequent infections____	Adverse drug _____
Eyesight _____	Significant injuries _____	Endocrine/growth_____	Other problems ___

Dental History

Please elaborate on any items checked:

Yes___No___ Has your child ever been to the dentist? _____
Name of dentist and date last seen_____

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? _____

Yes___ No___ Does your child have pain with chewing, yawning, or wide opening? _____

Yes___ No___ Does your child's jaw make noise and is pain associated with the sounds?
_____

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

Cavities _____	Toothache _____	Teeth Sensitive_____
Trauma _____	Gum Infections_____	Color of teeth _____
Orthodontics _____	Jaw Sounds_____	Other _____

Comments:

_____

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Thank you for your information!
Dr. Jennifer Ochoa & Dr. Christina Gonzales