

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: Child

Parent Social Security #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Allergies
_____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other
_____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | _____ |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory
Problems | Immunizations |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | . DPT#1(2mo) |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism | . DPT#2(4mo) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | . DPT#3(6mo) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | . DPT#4(15mo) |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke | . Polio(2mo) |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Venereal Disease | . Polio(18mo) |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors | . MMR(15mo) |
| | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers | |
| | <input type="checkbox"/> Nervous Disorders | | |

• Name of pediatrician or family physician: _____ Telephone number: _____

• Is your child currently taking any medication? Yes No If yes please list: _____

• Has your child ever had any complications following dental treatment? Yes No
If yes, please explain: _____

• Has your child been admitted to a hospital or needed emergency care during the past years? Yes No
If yes, please explain: _____

• Are they now under the care of a physician? Yes No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do they have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Website School Work Other _____

Name of person or office referring you to our practice: _____

Dental History

1. Is this your child's first visit to a dentist? Yes No If NO date of last examination: _____
Dentist name and address: _____
Was it satisfactory? Yes No Were x-rays taken? Yes No
2. Has your child ever had any of the following?

<input type="checkbox"/> Dental Decay	<input type="checkbox"/> Abscesses	<input type="checkbox"/> Toothaches
<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Stained teeth	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Injury
<input type="checkbox"/> Sensitive teeth	<input type="checkbox"/> Other _____	
3. Does (or did) your child have any habits which may affect oral health?
 Clenching or grinding teeth Mouth Breathing Finger or thumb habits
 Pacifier Habit Lip/Tongue sucking Other _____
4. Does your child have a speech problem? Yes No Explain _____
5. Tooth Cleaning Inventory: Frequency: Daily Every other day Weekly Times p.day _____
When: _____
Type of toothbrush _____ Type of toothpaste? _____ Amount _____
Dental floss Yes No
Disclosing tablet Yes No
Who is responsible for tooth cleaning? Parent Child Both
Reasons for brushing/flossing your child's teeth? _____
Have you received instructions on how to control dental disease? Yes No
6. Fluoride Inventory:
Is your child using?

Water fluoridation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
Fluoride supplements	<input type="checkbox"/> Yes <input type="checkbox"/> No	What kind? _____
Fluoride rinse	<input type="checkbox"/> Yes <input type="checkbox"/> No	What kind? _____
Fluoride toothpaste	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Does your child snack? Yes No Favorite snacks: _____
8. Do any of these favor or promote dental decay? Yes No _____
9. Is there a history of tooth decay in the family? Yes No
Favorite drinks: _____

Mother's side	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Father's side	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Brother's side	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sister's side	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Has anyone in the family worn braces? Yes No Who? _____
11. Are you familiar with the term "Preventive Dentistry" Yes No
12. Are you aware of sealants(plastic coating for teeth)? Yes No
13. Is there a history of missing/extra teeth in the family? Yes No
14. Are you interested in a program to teach you and your child how to control dental disease?
 Yes No Why: _____
15. Have you noticed gray in the back of your child's mouth?
 Yes No
16. Is there anything with your child's smile you would like to improve?
 Yes No

I give permission to Dr. Arias and his staff to treat my child who is names above. I understand that Dr. Arias and such assistants as he may designate to treat the aboved name patient will use restorative, oral surgery and patient management techniques that are reasonable, and necessary and advisable. I also authorize the administration of anesthetics or analgesics that may be deemed advisable by Dr. Arias. I understand that the treatment plan to be presented along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology. Furthermore, by signing this, I agree to be responsible for full payment of all charges for dental services performed on the above named patient.

Signed _____ Relationship _____ Date _____