

PARENTS BELIEFS ABOUT DENTAL DISEASE

Do you believe:

- 1. dental disease is inherited? yes no
- 2. lack of milk in the diet leads to weaker teeth? yes no
- 3. brushing alone will keep teeth and gums healthy? yes no
- 4. eating the right foods (diet) is enough to prevent cavities and gum disease? yes no
- 5. you can inherit weak teeth? yes no
- 6. your child is capable of properly brushing/flossing his own teeth and gums? yes no

DENTAL HISTORY

1. Is this your child's first visit to a dentist? yes no If NO, give 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? Dental decay Abscesses(gum boils) Toothaches
 Bad breath Cold sores (fever blisters) Frequent sore throats
 Stained teeth Bleeding gums Injury to front teeth
 Sensitive teeth Other: _____
 Explain: _____
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: _____
 Explain: _____
4. Does your child have a speech problem? yes no Explain: _____
5. Tooth Cleaning inventory: Frequency: Daily Every other day Weekly Times per day: _____
 When? _____
 Type of toothbrush: _____ Type of toothpaste? _____ Amount? _____
 Dental Floss yes no
 Disclosing tablets yes no
 Who is responsible for tooth cleaning? Parent Child Both
 Reasons for brushing/flossing your child's teeth and gums? _____
 Have you receive instructions on how to control dental disease? yes no
6. Fluoride Inventory: Water fluoridation yes no Unsure
 Is your child using: Fluoride supplements yes no What kind? _____
 Fluoride rinse yes no What kind? _____
 Fluoride toothpaste yes no
7. Does your child snack? yes no List a few of his favorite snacks? _____
8. Do you feel any of these favor or promote dental decay? yes no
9. Is there a history of tooth decay in the family? yes no
 Mother's side yes no Explain: _____
 Father's side yes no _____
 Brother's yes no _____
 Sister's yes no _____
 Comments: _____
10. Has any one 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 or extra teeth in the family? yes no Who? _____
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

Additional comments: _____

I give my permission to Dr. Francisco Arias and his staff to treat my child who is named above. I understand that Dr. Francisco Arias and such assistants as he may designate to treat the aboved named 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 TO CHILD _____ DATE _____
 (healthqu.doc)

PLEASE COMPLETE THIS QUESTIONNAIRE. ALL INFORMATION IS CONFIDENTIAL. ALL INFORMATION AIDS US IN UNDERSTANDING YOUR CHILD BETTER.

GENERAL INFORMATION

Child's name: _____ Age: _____ Years and _____ Months. Sex: Male Female Weight: _____
 What is the reason for this appointment? consultation complete exam pain other: _____
 What is the parent's level of dental apprehension? high medium low none
 Describe your child (check as many as apply): aggressive friendly active spoiled
 quiet timid talkative manageable
 unmanageable talkative insecure independent
 How do you think your child will respond today? well moderately well moderately bad bad don't know

MATERNAL-PRENATAL HISTORY

Was child adopted? yes no If no, please answer the following questions:
 Did you have a normal pregnancy and delivery? yes no Explain _____
 Any difficulties or complications during pregnancy? yes no Explain _____
 Experience any of the following during pregnancy? Severe morning sickness Taking medications, antibiotics, etc...
 Physical trauma or injury illness (other than colds or flu)
 Other Explain _____

BIRTH HISTORY

Full term Premature _____ wks Normal Delivery Forceps Delivery Cesarean Delivery
 Complications during delivery; please explain: _____
 Birth weight _____ lbs. Birth length _____ in.

NEONATAL HISTORY (Birth-1 month)

Did your infance experience any of the following? Jaundice Breathing difficulties Feeding difficulties
 High fevers Serious illness Intubation
 Other Explain _____

GROWTH AND DEVELOPMENTAL MILESTONES

Sitting alone _____ mo. Crawling _____ mo. First word _____ mo.
 First tooth _____ mo. Standing alone _____ mo. Walking alone _____ mo.

FEEDING HISTORY

Breast Fed Bottle Fed
 Totally. How long? _____ Mo. Ready-to-feed formula
 Schedule frequency Formula reconstituted with water
 On demand feeding Other
 Bedtime feeding Average time of each feeding _____
 Supplemental bottle. When began? _____ Mo. Bed time bottle Yes No Contents _____
 Weaned _____ mo. Bottle used as pacifier Yes No Contents _____
 Age bottle discontinue _____

MEDICAL HISTORY

1. Does your child have any medical problems? Explain _____ yes no
 2. Did your child have a history of health problems at birth or during his initial years? yes no
 3. Is your child taking any medication or drugs at this time? yes no
 4. Has your child ever had any unfavorable reactions to food, drugs or medicines? yes no
 5. Has your child ever been hospitalized or injured? yes no
 When _____ Where _____ Why _____
 6. Does your child have any limitation to physical activities? Explain _____ yes no
 7. Has your child had any history of the following? Allergies Breathing problems Rheumatic fever Asthma
 Diabetes Kidney/liver problems Heart trouble Blood disorders Mental/emotional problems Ear infections
 HIV-Aids Convulsions Hepatitis Cancer Other _____
 Explain _____
 8. Does your child have regular medical evaluations? yes no Date of last medical examination: _____
 9. Name of pediatrician or family physician: _____
 10. Current Immunization: DPT#1(2mo.) DPT#2(4mo) DPT#3(6mo) DPT#4(15mo)
 Polio (2mo) Polio (18mo) Measles, mumps, rubella (15mo).
 11. Does your child have problems in (for children 24 mo. and older)
 Concentrating learning Cooperating Understanding
 12. How do you discipline your child? _____
 13. Is there additional medical information we should know? _____