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:

- ☐ AIDS
- ☐ Allergies
_____
_____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Tuberculosis
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Venereal Disease
- ☐ Tumors
- ☐ Ulcers
- ☐ Penicillin Allergy
- ☐ Codeine Allergy
- ☐ Other
_____
_____

Immunizations
- DPT#1(2mo)
- DPT#2(4mo)
- DPT#3(6mo)
- DPT#4(15mo)
- Polio(2mo)
- Polio(18mo)
- MMR(15mo)

- 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 you 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.

_____ Date: _____
Signature of patient, parent or guardian

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?** __Dental Decay __Abscesses __Toothaches
   __Bad Breath __Cold Sores __Sore throat
   __Stained teeth __Bleeding gums __Injury
   __Sensitive teeth __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:** **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
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
   Mother's side __Yes__No
   Father's side __Yes__No
   Brother's side __Yes__No
   Sister's side __Yes__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

Favorite snacks:_____
_____
_____
Favorite drinks:_____
_____
_____

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**_____