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& ASSOCIATES

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Child's Dental History

CHILD'S NAME: _____ ☐ Male ☐ Female

CHILD'S PREFERRED NAME: _____ **CHILD'S BIRTHDAY:** _____

CHILD RESIDES WITH: ☐ Mother & Father ☐ Mother ☐ Father ☐ Other: _____

CHILD'S SCHOOL: _____

CHILD'S PHYSICIAN: _____ **LAST EXAM:** _____

_____
Address

CHILD'S PREVIOUS DENTIST: _____ **LAST EXAM:** _____

CHILD'S ORTHODONTIST: _____ **LAST EXAM:** _____

REASON FOR TODAY'S APPOINTMENT: _____

		YES	NO	*Please explain any YES answer*
1.	Has child ever had dental radiographys (x-rays)?	☐	☐	
2.	Has child ever reacted unfavorably to dental treatment?	☐	☐	
3.	Has child had an allergic reaction to local anesthesia (Novocaine, Lidocaine, Citanest)?	☐	☐	
4.	Has child ever been a habitual thumb-sucker? Finger-sucker? Pacificer?	☐	☐	
5.	Did child have bottle past one year? To what age?	☐	☐	
6.	Does child have full charge of his/her own toothbrushing?	☐	☐	
7.	Have you observed or been previously advised that orthodontic treatment is necessary?	☐	☐	
8.	Is child a heavy "sweets" eater? How many times a day does he/she eat sugar?	☐	☐	
9.	Has child ever suffered a severe blow to the teeth, face or head?	☐	☐	
10.	Has child ever suffered from a high fever?	☐	☐	
11.	Has child ever been treated for any gum disease (e.g. gingivitis, juvenile periodontitis, periodontitis, pyorrhea, trench mouth)	☐	☐	
12.	Does child's gum bleed when brushing?	☐	☐	
13.	Does child grind or clinch teeth?	☐	☐	
14.	Has your child taken flyoride vitamins or drops in the past? What age?	☐	☐	
15.	Does your child currently take a fluoride supplement?	☐	☐	
16.	What is the name of the water company to which you pay your water bill?	☐	☐	

Member
American Academy
of Pediatric Denstiry

–

California Society
of Pediatric Dentistry

–

American Board
of Pediatric Dentistry

Child's Medical History

HISTORY

	YES	NO	REVIEWER COMMENTS
1. Is your child being treated by a physician at this time? If yes, why? _____	☐	☐	_____
2. Has your child ever been a patient in a hospital? If yes, why? _____	☐	☐	_____
3. Has your child ever received general anesthesia or sedation? If yes, when? _____	☐	☐	_____
4. Is your child allergic to anything? (Medicine, food) If yes, what? _____	☐	☐	_____
5. Is your child taking any medication at this time? If yes, what? _____	☐	☐	_____
6. Has your child ever had a serious illness or operation? If yes, for what? _____	☐	☐	_____
7. Has your child ever had a blood transfusion?	☐	☐	_____
8. Does your child smoke or use tobacco products?	☐	☐	_____

ORGANS AND SYSTEMS

Has this child ever had any treatment for any of the following? Please check Yes or No:

YES	NO		YES	NO		YES	NO	
☐	☐	Blood - Circulatory	☐	☐	Gastrointestinal - stomach	☐	☐	Muscles
☐	☐	Bones	☐	☐	Kidney - Bladder	☐	☐	Nervous System
☐	☐	Endocrine Glands	☐	☐	Heart	☐	☐	Skin
☐	☐	Eyes, Ears, Nose, Throat	☐	☐	Liver	☐	☐	Tonsils/Adenoids
☐	☐	Respiratory - Lungs						

☐ This child has NOT had any treatments for the above.

ILLNESS

Has this child ever been diagnosed as having any of the following conditions? ***Please check each box 'Yes' or 'No':***

YES	NO		YES	NO		YES	NO	
☐	☐	AIDS (Immunosupressive Disorder)	☐	☐	Excessive Bleeding Problem	☐	☐	Premature Birth
☐	☐	Anemia	☐	☐	Fainting	☐	☐	Psychiatric Disorder
☐	☐	Allergy	☐	☐	Hearintg Loss	☐	☐	Pheumatic Fever
☐	☐	Arthritis	☐	☐	Heart Disease	☐	☐	Scarlet Fever
☐	☐	Asthma	☐	☐	Hemophilia	☐	☐	Scoliosis
☐	☐	Autism (or ASD)	☐	☐	Hepatitis - Type	☐	☐	Sickle Cell Anemia
☐	☐	Brain Injury	☐	☐	Jaundice	☐	☐	Hepatitis - Type
☐	☐	Bronchitis	☐	☐	Leukemia	☐	☐	Sinus Probelms
☐	☐	Cancer	☐	☐	Measles	☐	☐	Snoring at Night
☐	☐	Cerebral Palsy	☐	☐	Intellectual Disability	☐	☐	Spina Bifida
☐	☐	Clef Lip/Palate	☐	☐	Mouth Breathing	☐	☐	Syndrome
☐	☐	Convulsions/Seizures	☐	☐	Nutritional Deficiency	☐	☐	Tetanus
☐	☐	Diabetes	☐	☐	Orthopedic Problems	☐	☐	Tuberculosis
☐	☐	Drug or Alcohol Abuse	☐	☐	Pregnancy	☐	☐	Venereal Disease
☐	☐	Epilepsy	☐	☐	Pneumnia	☐	☐	Whooping Cough
☐	☐	Eye Problems	☐	☐	Polio	☐	☐	Other

☐ This child has never been dianosed as having any of the above conditions.

Is there anything else that you think we should know about your child? _____

Reviewed by _____ Date _____

CONSENT

I certify that I have read and understood the preceding questions and certify to the truth of all information given. I will not hold *David A. Chin, D.D.S. and Associates* or any member of his staff responsible for errors or omissions I may have made in the completion of this form.

I understand that the information given will be held in the strictest confidence and it is my responsibility to inform this office or any changes in my child's health status without fail at the next appointment.

If I request to have **NO** radiographs taken of my child against the advice of Dr. Chin, I understand I will take full responsibility for and release the Doctor from any liability should a problem arise in the future. Since your child is a minor, it is necessary that a signed permission be obtained.

Since your child is a minor, it is necessary that a signed permission be obtained from a parent or legal guardian prior to any/or all dental services can be started and accomplished by Dr. Chin and/or legally qualified staff members.

Authorization is hereby granted to do an examination, take appropriate x-rays, clean the teeth, give a fluoride treatment, and provide oral hygiene instructions if deemed necssary. Following consultation, authorization is also granted to administer any treatment, anesthetics, and perform such operations or otherwise manage my child as may be deemed necessary or advisable. Dr. Chin may choose and employ such assistance as he may deem fit. I also give permission to provide emergency care if needed.

I futher understand this content will remain in effect until such time that I choose it to be terminated.

Signature _____ Relationship to patient _____ Date _____