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Palm Springs, CA. 92262

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PEDIATRIC DENTISTRY HEALTH HISTORY AND PATIENT INFORMATION

This confidential information is of great value in aiding us to better understand and treat your child.

REASON FOR VIST_____ **Date**_____

Child's Name_____ Pref.Name_____ SEX M F

Age_____ Date of Birth_____ School _____ Grade _____

Name & Age of Brothers & Sisters _____

Kind & Name of any pet(s) _____

What is your child most interested in? _____

Child's Physician_____ Phone Number _____

City_____ Date last seen _____

Family Dentist_____ City _____

HISTORY **CIRCLE**

1. Is your child being treated by a physician at this time? ..... YES NO
   If yes, Why? _____
2. Has your child ever been hospitalized or had surgery? ..... YES NO
   If yes, Why? _____
3. Has your child ever received general anesthesia or sedation? ..... YES NO
   If yes, why, and when? _____
4. Is your child allergic to anything? (Medicine / Food /Latex) ..... YES NO
   If yes, what? _____
5. Is your child taking any medications at this time? ..... YES NO
   If yes, medicine and dosage _____
6. Has your child ever had a blood transfusion? ..... YES NO
7. Does your child have any blood disorders (anemia, etc.)? ..... YES NO
8. Is your child subject to any nervous disorders, fainting or dizziness? ..... YES NO
9. Does your child bruise easily? ..... YES NO
10. Has your child a history of heart trouble, murmurs or rheumatic fever? ..... YES NO
11. Has your child a history of asthma? ..... YES NO
12. Has your child a history of diabetes? ..... YES NO
13. Does your child have a handicapped problem or learning disabilities? ..... YES NO
14. Is this your child's first dental visit? ..... YES NO
    Previous dentist _____ City _____ Last seen _____
15. Has your child had an unfavorable experience in a previous dental / medical office? ..... YES NO
    How do you think he/she will act toward the dentist? _____
16. At what age did your child stop bottle/breast feeding? _____
17. Have there been any injuries to your child's teeth or jaws? (falls, blows, chips, etc.) ..... YES NO
18. Is your child taking a fluoride supplement or drinking fluoridated water? ..... YES NO
19. Does you child suck his/her thumb or fingers? ..... YES NO
20. How often does your child brush his/her teeth? _____
21. What type of toothpaste does your child use? _____
22. Is dental floss used? ..... YES NO
23. Does your child have a problem with his/her bite or position of any teeth? ..... YES NO
24. Is there any history of missing or extra teeth in the family? ..... YES NO
25. Has your child been seen by an orthodontist? ..... YES NO
26. Has your child had any sores or swellings of his/her mouth or jaws? ..... YES NO
27. Has your child had frequent sores in his/her mouth? ..... YES NO
28. Has your child ever had dental radiographs (X-rays) made? ..... YES NO
    If yes, when? _____
29. Have you been satisfied with your child's previous dental care? ..... YES NO
    If no, why? _____
30. Is your child adopted? ..... YES NO
    Does your child know? ..... YES NO
31. Who referred you to our office? _____
32. Is there anything else we should know about your child? _____
    _____

>>>>>>>>>>PLEASE COMPLETE REVERSE SIDE ALSO<<<<<<<<<<

ORGANS AND SYSTEMS

Has this child had any treatment for any of the following? Please circle all that apply:

Blood – Circulatory	Eye	Liver	Respiratory – Lungs
Bones	Gastrointestinal – Stomach	Muscles	Skin
Endocrine Glands	Kidney – Bladder	Nervous System	Tonsils / Adenoids
Ears	Heart	Nose / Throat	

ILLNESS

Has the child ever been diagnosed as having any of the following conditions? Please circle all that apply:

Anemia	Diphtheria	Measles	Sickle Cell Anemia
Allergy	Drug or Alcohol Abuse	Mental Retardation	Sinus Problems
Arthritis	Emphysema	Mumps	Skin Rash / Hives
Asthma / Hay fever	Epilepsy	Mouth Breathing	Snoring At Night
Autism	Eye Problems	Nutritional Deficiency	Spina Bifida
Brain Injury	Excessive Bleeding Problem	Orthopedic Problems	Syndrome _____
Bronchitis	Fainting	Pregnancy / Pregnant	Tetanus
Cancer	Hearing loss	Pneumonia	Thyroid Disease
Cerebral Palsy	Heart Disease	Polio	Tuberculosis
Chicken Pox	Hemophilia	Premature Birth	Venereal Disease
Cleft Lip / Palate	Hepatitis – Type_____	Psychiatric Disorder	Whooping Cough
Convulsions / Seizures	AIDS	Rheumatic Fever	Other _____
Developmental Disabilities	Jaundice	Scarlet Fever	_____
Diabetes	Leukemia	Scoliosis	_____

FAMILY INFORMATION

Residential Address of Patient_____ City_____ Zip_____

Parent 1 _____ Phone _____ Birthdate _____
Residential Address _____ City_____ Zip _____
Social Security No. _____ Drivers License No. _____
Employer _____ Occupation _____ Phone _____
Business Address _____ City _____ Zip _____

Parent 2 _____ Phone _____ Birthdate _____
Residential Address _____ City_____ Zip _____
Social Security No. _____ Drivers License No. _____
Employer _____ Occupation _____ Phone _____
Business Address _____ City _____ Zip _____

FINANCIAL RESPONSIBILITY & OFFICE POLICY

Please ***initial*** your acknowledgment of the following:

_____ Financial Responsibility shall fall unto the parent/guardian who brings the child(ren) to their dental appointment. Any balance remaining on the Family Account will be billed to whichever parent/guardian the child resides with.

_____ **Please Note**: It is **NOT** to be assumed that Financial Responsibility is held by the parent/guardian who carries the insurance policy.

_____ Payment is expected for services rendered at the time of visit.

_____ We have the right to charge $25 for any missed, cancelled, or rescheduled office visits, exam, and/or cleaning appointments without a 24 hour notice during our normal business hours. ($60 for treatment appointments)

_____ Our business hours are Monday-Wednesday, 8AM-5PM (Lunch 1PM-2PM) & Thursday, 9AM-6PM (Lunch 1PM-2PM) & closed Friday-Sunday.

_____ **Please Note**: If you call outside of our normal business hours & reach the answering service, it is an **EMERGENCY LINE ONLY**. They will not take down messages to make any changes to appointments. Any appointment changes or questions are to be made during our normal business hours.

AUTHORIZATION

I here by authorize Dr. Lauren L. Gutenberg and/ or her associates to perform any and all treatment for my above named child, and consent to such methods, drugs, and agents as may be indicated in connection with his / her dental care. This consent shall remain in effect until cancelled.

Signature _____ **Date** _____
Relationship to child _____