Pacific Pediatric Dentistry

Dental Practice of : T. Dean Walker, D.D.S., M.S. Larry V. Smith, D.D.S., M.P.H. Kristin L. Newsom, D.D.S., M.S.

Thank you for bringing your child to our office for dental care. In order to best understand and treat your child we have found the following information to be essential.

1. Child's Name: _____ M ☐ F ☐ Age: _____
   Last First Middle (Nickname)
2. Date of Birth: _____ Home Phone: _____ Cell Phone: _____
3. Child's Home Address: _____
   Street City State Zip Code
4. Name of person supplying the information for this history and relationship to child: _____
5. Child's present physician: _____ Last date of care: _____
6. Dentist: _____ Date of child's last dental examination or treatment: _____
7. Is your child currently under treatment by an orthodontist? _____ Orthondontist Name: _____
8. Explain briefly why you brought your child for dental care: _____

	Check one	Yes	No
9.	Is your child under treatment by a physician or have a health problem?……	☐	☐
10.	Has your child experienced any unfavorable reaction to any medicine such as penicillin, aspirin, barbituates, or local anesthetics?……..	☐	☐
11.	Is your child sensitive or allergic to anything? If yes, what? _____	☐	☐
12.	Is your child currently taking any medicine? If yes, what? _____	☐	☐
13.	Does your child have difficulty breathing through his/her nose?……	☐	☐
14.	Has your child ever been hospitalized? If so, at what age and for what reason? _____	☐	☐
15.	Does your child suck his/her thumb or finger?……..	☐	☐
16.	Does your child grit or grind his/her teeth during the day or night?……	☐	☐
17.	Does your child have a fear of medical personnel (nurses or physicians)?……	☐	☐
18.	Does your child ever complain of discomfort in his/her teeth when eating hot or cold foods, sweets, or when biting or chewing?……..	☐	☐
19.	Has your child ever injured his/her front teeth?……..	☐	☐
20.	Has your child had a previous dental experience (pleasant or unpleasant) which you feel we should know about? If yes, explain _____	☐	☐
21.	Do you feel there are any factors in your family which might cause your child to be under emotional stress at this time? If yes, explain _____	☐	☐
22.	Is it difficult to stop any bleeding when your child is cut or injured?……..	☐	☐
23.	Is your child taking fluoride drops or tablets at the present time?……	☐	☐
24.	Have we treated any other children in your family?……	☐	☐

25. Has your child had any history of the following?

☐ Yes ☐ No Fainting or Dizziness	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No AIDS
☐ Yes ☐ No Nervousness	☐ Yes ☐ No Asthma	☐ Yes ☐ No Skin rash/Hives
☐ Yes ☐ No Tuberculosis	☐ Yes ☐ No Rheumatic Fever	☐ Yes ☐ No Liver involvement
☐ Yes ☐ No Bleeding disorders	☐ Yes ☐ No Radiation treatment	☐ Yes ☐ No Kidney involvement
☐ Yes ☐ No Cold sores/Fever blisters	☐ Yes ☐ No Latex Allergy	☐ Yes ☐ No Hyperactivity
☐ Yes ☐ No Diabetes	☐ Yes ☐ No Anemia	
☐ Yes ☐ No Heart trouble or congenital heart lesions	Other _____	

26. What is your child's weight? _____ Lbs. 25.What grade is your child? _____
27. Do you consider your child to be: (check one)……☐Advanced ☐ Normal ☐ Slower than average
28. Is there anything unusual about your child, not already mentioned, that you think we should know about?
If yes, explain. _____

We are required to obtain parental consent before any dental treatment can be rendered for your child. I hereby authorize that all necessary dental services be given for the child named above. This shall include the taking of necessary records (photographs, x-rays, motion pictures, study models) and the administration of local anesthetics or other medications deemed necessary by the doctor. In addition, these records may be used for reproduction in scientific articles or professional books intended for publication or for exhibit under the auspices of a scientific group.

Although your insurance may cover your dental treatment, you are fully responsible for all fees incurred for dental treatment provided by Dr. Walker, Dr. Smith & Dr. Newsom. We will submit your dental claims for you as a courtesy, however it is your responsibility to ensure that all treatment fees are paid for.

Date: _____ Relationship to child: _____ Signature: _____

Parent Updates & Dr. Reviewed: _____ _____ _____