Antioch Brentwood Pediatric Dentistry

THE INFORMATION YOU INCLUDE ENABLES US TO PROVIDE BETTER CARE FOR YOUR CHILD

Child's name ______________________________ Nickname ____________

First Middle Last

Sex: M ___ F ___ Birthdate ____________ Adoption or guardianship ____________

What is the reason for this visit? ______________________________

Is this your child's first dental visit? ________ Date of last visit? ________ Purpose ____________

What was your child's attitude towards previous dental care? ______________________________

Have we seen other children in your family? ______________________________

Name and age of brothers and sisters ______________________________

Name of child's pet ____________ Child's interests ______________________________

Name of family dentist ____________ Child's previous dentist ______________________________

Who may we thank for referring you to our office? ______________________________

MEDICAL INFORMATION

Child's pediatrician ______________________________ Phone number ____________

Date of last physical exam ____________ Is your child under a doctor's care now? ____________

For what reason? ______________________________

Is your child taking any medication or drugs? ________ Please list: ______________________________

For what reason? ______________________________

Has your child ever been hospitalized? ________ When? ______________________________

For what reason? ______________________________

Is your child allergic to any medications? ______ Please list: ______________________________

Describe the reaction ______________________________

Does your child have an allergic reaction to food? ______ animals? ______ pollen? ______ dust? ______ latex? ______

Does your child have good physical co-ordination? ______________________________

Are your child's immunizations up-to-date? ______________________________

Has your child had a history or difficulty with any of the following:

YES	NO		YES	NO		YES	NO	
___	___	Allergies to Medication	___	___	Bleeding Problems	___	___	Hearing Difficulties
___	___	Premature Birth	___	___	Nosebleeds	___	___	Earaches
___	___	First Year of Life	___	___	Bruising	___	___	Gag Reflex
___	___	Heart Problems	___	___	Anemia	___	___	Motion Sickness
___	___	Rheumatic Fever	___	___	Hepatitis	___	___	Cancer or Malignancies
___	___	Asthma	___	___	Brain Injury	___	___	Kidney Problems
___	___	Seizures	___	___	Cerebral Palsy	___	___	Fainting or Dizziness
___	___	Diabetes	___	___	Bone Disorder	___	___	Speech Disorder
___	___	Immune Disorder / HIV / AIDS	___	___	Liver Problems	___	___	Reflux or Regurgitation
___	___	Tuberculosis	___	___	Delayed Development	___	___	Eczema

Comments/Details ______________________________

______________________________ Reviewed History:

Does your child have any phobias? ________ Any emotional or school problems? ____________

How would you describe your child's learning: Slow ________ Average ________ Accelerated ________

To the best of my knowledge the above information is true. Signature______________________ **Date**__________

Leslie Tanimura, DDS, MSD • Jennifer Lo, DMD, MS

DENTAL INFORMATION

Was your child bottle fed? ________________ Until what age? __________________ Breast fed? ________________ Until what age? _____________

Does your child have any mouth habits such as: Finger/thumb sucking _______________ Tooth grinding ___________________

Lip sucking _______________ Mouth breathing _______________ Pacifier ________________ Nail biting ________________Other________________

Has your child ever had any injuries to his/her teeth, mouth or head? ____

If yes, please describe ____

Has your child taken fluoride? _________ In what form and when? ____

Does your child brush regularly? ________________________________Does an adult assist with brushing? ____________________

Does your child use dental floss? ______________________________Does an adult assist with flossing? _____________________

Has either parent or child been treated orthodontically? ____

How do you expect your child to behave in our office? ____

Describe your child: Outgoing_________ Shy_________ Stubborn_________ Anxious_________ Frightened_________ Regular kid ___________

How may we make this visit a positive experience for your child? _____________________________________

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GENERAL INFORMATION

This information is requested for financial and credit purposes.

Name of person who is financially responsible for this child ____

FATHER (full name) _______________________________________Date of birth _____________ Marital status _____________

Home address __________________________________ City/State ___________________Zip _____________ Home phone _____________

Employer __________________________ Address ______________________________ City _____________ Work phone ______________

Social security number _________________________________ Driver's license number _____________________________________

Email ____

MOTHER (full name) _______________________________________Date of birth _____________ Marital status _____________

Home address __________________________________ City/State ___________________Zip _____________ Home phone _____________

Employer __________________________ Address ______________________________ City _____________ Work phone ______________

Social security number _________________________________ Driver's license number _____________________________________

Email____

Child resides with: Both parents________________ Mother__________________ Father__________________ Other______________________

Name of nearest relative not living with you ____ Relationship ________________________

Address _____________________________ City/Zip _________________ Home phone __________________ Work phone ________________

INSURANCE INFORMATION AND CONSENT

FATHER **Name of Insurance Company** _______________________________ **Group/Policy No.** ___________________________

Address ____ Union Local _______________________________

MOTHER **Name of Insurance Company** _______________________________ **Group/Policy No.** ___________________________

Address ____ Union Local _______________________________

ASSIGNMENT OF BENEFITS I hereby authorize payment of the group dental benefits otherwise payable to me but not to exceed the charges shown on the claim. I understand that I am financially responsible for any charges not covered by this authorization.

SIGNATURE ____ **DATE** ___________________________________

CONSENT I give the dentist permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand, that when appropriate, credit bureau reports may be obtained.

SIGNATURE ____ **DATE** ___________________________________

RELATIONSHIP TO PATIENT ____

Leslie Tanimura, DDS, MSD • Jennifer Lo, DMD, MS