David A. Chin, D.D.S.
PEDIATRIC DENTISTRY

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CHILD'S NAME: _____ ❑ **Male** ❑ **Female**

CHILD'S NICKNAME: _____ **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 THIS APPOINTMENT: _____

CHILD'S DENTAL HISTORY

		Yes	No	*Please explain any YES answer*
1.	Has child ever had dental radiographs (x-rays)?	❑	❑	_____
2.	Has child ever reacted unfavorably to dental treatment?	❑	❑	_____
3.	Has child had an allergic reaction to local anesthesia (Novocain, Lidocaine, Citanest)?	❑	❑	_____
4.	Has child ever been a habitual thumb-sucker? Finger-sucker? Pacifier?	❑	❑	_____
5.	Did child have bottle past one year? To what age?	❑	❑	_____
6.	Does child have full charge of his /her own tooth brushing?	❑	❑	_____
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 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, pyorrhea, trench mouth)	❑	❑	_____
12.	Does child's gum bleed when brushing?	❑	❑	_____
13.	Does child grind or clinch teeth?	❑	❑	_____
14.	Has your child taken fluoride 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 which you pay your water bill?	❑	❑	_____

Member
American Academy
of Pediatric Dentistry

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 a medication at this time? If yes, when? _____	❑	❑	_____
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 treatment for the above.

ILLNESS

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

Yes	No		Yes	No		Yes	No	
❑	❑	AIDS (Immunosuppresive Disorder)	❑	❑	Eye Problems	❑	❑	Premature Birth
			❑	❑	Excessive Bleeding Problem	❑	❑	Psychiatric Disorder
❑	❑	Anemia	❑	❑	Fainting	❑	❑	Rheumatic Fever
❑	❑	Allergy	❑	❑	Hearing Loss	❑	❑	Scarlet Fevers
❑	❑	Arthritis	❑	❑	Heart Disease	❑	❑	Scoliosis
❑	❑	Asthma	❑	❑	Hemophilia	❑	❑	Sickle Cell Anemia
❑	❑	Autism	❑	❑	Hepatitis - Type _____	❑	❑	Sinus Problems
❑	❑	Brain Injury	❑	❑	Jaundice	❑	❑	Snoring at Night
❑	❑	Bronchitis	❑	❑	Leukemia	❑	❑	Sore Throats - Frequent
❑	❑	Cancer	❑	❑	Measles	❑	❑	Spina Bifida
❑	❑	Cerebral Palsy	❑	❑	Mental Retardation	❑	❑	Syndrome _____
❑	❑	Chicken Pox	❑	❑	Mumps	❑	❑	Tetanus
❑	❑	Cleft Lip/Palate	❑	❑	Mouth Breathing	❑	❑	Tuberculosis
❑	❑	Convulsions/Seizures	❑	❑	Nutritional Deficiency	❑	❑	Venereal Disease
❑	❑	Diabetes	❑	❑	Orthopedic Problems	❑	❑	Whooping Cough
❑	❑	Diptheria	❑	❑	Pregnancy	❑	❑	Other _____
❑	❑	Drug or Alcohol Abuse	❑	❑	Pneumonia	❑	❑	_____
❑	❑	Epilepsy	❑	❑	Polio	❑	❑	_____

❑ This child has never been diagnosed as having any of the above conditions. Is there anything else that you think we should know about your child?_____

CONSENT

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

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

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 is 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 necessary. Following consultation, authorization is also granted to administer any treatment, anesthetics, and perfom 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 further understand this consent will remain in effect until such time that I choose it to be terminated.

Signature _____ Relationship to Patient _____ Date _____