

Maria Aslani-Breit, D.D.S., PLLC.
Pediatric Dentistry

PATIENT'S PERSONAL DATA

Patient Name: _____ Date of Birth: ____/____/____ Sex: M F
LAST FIRST MIDDLE

Nickname: _____ School: _____ Grade: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Preferred Family E-mail Address: _____

Preferred Pharmacy Name and Address: _____

Father's/Guardian's Name: _____

Mother's/Guardian's Name: _____

Parent's Marital Status: Single Married Separated Divorced Widowed

How did you hear about our office? _____

Do you/patient have any religious and/or cultural beliefs that would affect treatment? _____

PEDIATRIC MEDICAL HISTORY

Child's Pediatrician: _____ Date of last physical exam: ____/____/____
 Pediatrician's address: _____ Pediatrician's phone #: (____) _____

| | YES | NO |
|---|---|--|
| Does your child have any CURRENT HEALTH PROBLEMS? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your child under a Physician's care now? (If YES, see below) | <input type="checkbox"/> | <input type="checkbox"/> |
| For what? | | |
| Is your child currently taking any medications? (If yes, list below) | <input type="checkbox"/> | <input type="checkbox"/> |
| Medications: | | |
| Has your child ever had a serious illness, operation, or hospitalization? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, for what? When? | | |
| Are your child's immunizations up-to-date? | <input type="checkbox"/> | <input type="checkbox"/> |
| CHECK ANY OF THE FOLLOWING YOUR CHILD HAS HAD OR PRESENTLY HAS: | | |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Allergies/Hives | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Sickle Cell Anemia/Trait | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Brain Injury |
| <input type="checkbox"/> Tuberculosis | | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Developmental Delays | | <input type="checkbox"/> Speech Disorder |
| <input type="checkbox"/> Emotional Disorder | | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Tumors/Growths/Radiation Therapy | | <input type="checkbox"/> Artificial Joints/Pins/Plates |
| <input type="checkbox"/> Congenital Birth Defects | | |
| Other: _____ | | |
| Please explain any YES answers to the above questions: _____ | | |
| _____ | | |
| _____ | | |
| IS YOUR CHILD ALLERGIC TO OR HAS (S)HE REACTED ADVERSELY TO ANY OF THE FOLLOWING: | | |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other Antibiotics |
| <input type="checkbox"/> Metal | <input type="checkbox"/> Latex | |
| <input type="checkbox"/> None | Other medicines or substances? _____ | |
| <p>To the best of my knowledge, the above questions have been answered accurately. I hereby consent to the initial examination, including the taking of diagnostic radiographs (x-rays), photographs and casts as deemed necessary by Doctor to make a thorough diagnosis of the patient's dental needs. I understand that I should always accompany my child for care and it is my responsibility to inform this office of any changes in my child's medical status.</p> | | |
| Date: ____/____/____ | Signature: _____ | Relationship to patient: _____ |