Maria Aslani-Breit, D.D.S., P.L.L.C.
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?	☐	☐
Is your child under a Physician's care now? (If YES, see below)	☐	☐
For what?		
Is your child currently taking any medications? (If yes, list below)	☐	☐
Medications:		
Has your child ever had a serious illness, operation, or hospitalization?	☐	☐
If so, for what? When?		
Are your child's immunizations up-to-date?	☐	☐

CHECK ANY OF THE FOLLOWING YOUR CHILD HAS HAD OR PRESENTLY HAS:

☐ Rheumatic Fever	☐ Allergies/Hives	☐ Hemophilia	☐ Developmental Delays
☐ Heart Disease	☐ Hepatitis/Liver Disease	☐ Bleeding Disorder	☐ Speech Disorder
☐ Heart Murmur	☐ Kidney Disease	☐ Blood Transfusions	☐ Emotional Disorder
☐ High Blood Pressure	☐ Diabetes	☐ HIV/AIDS	☐ Eating Disorder
☐ Lung Disease	☐ Sickle Cell Anemia/Trait	☐ Seizures	☐ Tumors/Growths/Radiation Therapy
☐ Asthma	☐ Anemia	☐ Brain Injury	☐ Artificial Joints/Pins/Plates
☐ Tuberculosis		☐ Autism	☐ 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:

☐ Aspirin	☐ Tylenol	☐ Local Anesthetics	☐ Nitrous Oxide	☐ Sedatives	☐ Penicillin
☐ Erythromycin	☐ Sulfa	☐ Other Antibiotics	☐ Metal	☐ Latex	
☐ None	Other medicines or substances? _____				

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.

Date: ____/____/____ Signature: _____ Relationship to patient: _____