DR. ____________________

X-RAY ________ (DATE) ________ (TIME)

IMP. ________ (DATE) ________ (TIME)

enhancing lives through beautiful smiles
3801 Las Posas Road, Suite 212
Camarillo, CA 93010
(805) 482-6636

1ST EXAM		
MONTH	DAY	YR

RE-CALL		
MONTH	DAY	YR

RE-CALL		
MONTH	DAY	YR

1) Last Name

2) First

GETTING TO KNOW YOU!

CHILD

A. GENERAL INFORMATION

LAST NAME (PLEASE PRINT)	FIRST	MIDDLE INITIAL	SEX M F	AGE (YRS & MOS)	PATIENT'S BIRTHDATE

HOME PHONE #	PATIENT'S ADDRESS	STREET	CITY	STATE	ZIP CODE

HOBBIES/SPORTS/INTERESTS	SCHOOL	GRADE

MOTHER'S LAST NAME	FIRST	BIRTHDATE	HOME ADDRESS IF DIFF	PHONE #

MOTHER'S EMPLOYER	JOB TITLE	HOW LONG?	PHONE/FAX/BEEPER

INSURANCE CO.	SS #	DRIVER'S LICENSE #

FATHER'S LAST NAME	FIRST	BIRTHDATE	HOME ADDRESS IF DIFF.	PHONE #

FATHER'S EMPLOYER	JOB TITLE	HOW LONG?	PHONE/FAX/BEEPER

INSURANCE CO.	SS #	DRIVER'S LICENSE #

PARENT'S MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOW	PATIENT LIVES WITH	RELATIONSHIP

PERSON RESPONSIBLE FOR ACCOUNT	ADDRESS/PHONE #

PERSON (NOT LIVING WITH YOU) TO CONTACT IN CASE OF EMERGENCY NAME:	RELATIONSHIP:	ADDRESS:	PHONE:

HOW DID YOU HEAR OF OUR OFFICE?	BROTHERS/SISTERS (NAMES & AGES)

MEDICAL/DENTAL HISTORY

GENERAL DENTIST ____________ PHONE ____________
ADDRESS ____________
LAST VISIT: ____________
CHILDS PHYSICIAN ____________
PHONE: ____________
MEDICAL INSURANCE: ____________

	YES	NO
IS YOUR CHILD RECEIVING ANY MEDICATIONS OR DRUGS?	☐	☐
DOES YOUR CHILD NEED TO BE PRE-MEDICATED?	☐	☐
EXPLAIN:		
HAS YOUR CHILD EVER BEEN HOSPITALIZED?	☐	☐
IS YOUR CHILD IN GOOD HEALTH?	☐	☐
ANY INJURIES TO HEAD OR MOUTH?	☐	☐

DOES YOUR CHILD HAVE OR HAS HAD ANY OF THE FOLLOWING PROBLEMS?

	YES	NO
1. RHEUMATIC FEVER CONGENITAL HEART DISEASE	☐	☐
2. HEART MURMUR	☐	☐
3. ALLERGIES: A) FOOD, DUST, ETC.	☐	☐
B) DRUG, I.E. PENICILLIN, ETC.	☐	☐
C) LATEX, RUBBER PRODUCTS	☐	☐
D) FEN - PHAN	☐	☐
E) UNKNOWN	☐	☐
4. ASTHMA OR HAY FEVER	☐	☐
5. ARTHRITIS OR RHEUMATISM (PAINFUL SWOLLEN JOINTS)	☐	☐
6. DIABETES OR BLOOD SUGAR PROBLEMS	☐	☐
7. ANY PROLONGED BLEEDING OR BRUISES EASILY	☐	☐
8. KIDNEY OR BLADDER PROBLEMS	☐	☐
9. ANEMIA OR BLOOD DISORDERS	☐	☐
10. TUBERCULOSIS OR PNEUMONIA	☐	☐
11. LIVER PROBLEMS, JAUNDICE OR HEPATITIS	☐	☐
12. GLANDULAR OR HORMONAL PROBLEMS	☐	☐
13. ACCIDENTS OR SEVERE INFECTIONS	☐	☐
14. CONVULSION, SEIZURES, FAINTING OR EPILEPSY	☐	☐
15. HIGH/LOW BLOOD PRESSURE	☐	☐
16. SPEECH, LEARNING OR HEARING DISORDERS	☐	☐
17. CHILDHOOD ILLNESSES	☐	☐
18. IMMUNIZATIONS	☐	☐
19. HIV AIDS	☐	☐

ANY JAW CLICKING, LOCKING OR PAIN?	☐	☐
DOES CHILD CLENCH OR GRIND TEETH?	☐	☐

FAMILY MEMBERS IN TREATMENT WITH US: ____________

LAST VISIT: ____________
FAMILY MEMBERS WHO MAY NEED FUTURE ORTHODONTIC TREATMENT
NAME: ____________ BIRTHDATE: ____________
HAS EITHER PARENT HAD ORTHO TREATMENT?
WHO: ____________ WHEN: ____________

	YES	NO
ANY MOUTH HABITS: THUMBSUCKING, NAIL BITING, MOUTHBREATHING, ETC.?		
ANY PREVIOUS UNHAPPY DENTAL VISITS?	☐	☐
ANY LOST TEETH?	☐	☐
BABY TEETH REMOVED THAT WERE NOT LOOSE	☐	☐
CHIPPED OR OTHERWISE INJURED BABY OR PERMANENT TEETH	☐	☐
PERMANENT OR EXTRA TEETH REMOVED	☐	☐
TEETH SENSITIVE TO HOT OR COLD, TEETH THROB OR ACHE	☐	☐
'DEAD TEETH' - ROOT CANALS TREATED	☐	☐
BLEEDING GUMS - BAD TASTE - MOUTH ODOR	☐	☐
GINGIVITIS - 'VINCENTS' INFECTION - POCKETS	☐	☐
FOOD IMPACTION BETWEEN TEETH - PERIODONTAL PROBLEM	☐	☐
'GUM BOILS' - FREQUENT CANKER SORES - 'COLD SORES'	☐	☐
LIP - CHEEK - TONGUE BITING - SORENESS, OR BLEEDING	☐	☐

HAS CHILD EVER HAD ORTHODONTIC TREATMENT OR WORN A 'RETAINER' OR BITE PLATE?
____

IT IS MY RESPONSIBLITY TO ADVISE THE OFFICE OF ANY CHANGES IN PERSONAL/MEDICAL STATUS

PARENT'S INITIAL ☐

ARE THERE ANY PSYCHOLOGICAL OR EMOTIONAL PROBLEMS THAT SHOULD BE BROUGHT TO OUR ATTENTION? ____________
PLEASE SIGN THAT THIS INFORMATION IS ACCURATE AND COMPLETE.
SIGNATURE ____________
RELATIONSHIP ____________ DATE ____________
RECEIVED BY DR. ____________

REALIZING THAT SUCCESSFUL TREATMENT GREATLY DEPENDS UPON THE PATIENT'S COMPLETE COOPERATION IN FOLLOWING INSTRUCTIONS, KEEPING APPOINTMENTS AND MAINTAINING ORAL HYGIENE, ARE THERE ANY RESTRICTIONS, HANDICAPS OR PROBLEMS WE MIGHT ENCOUNTER? ____________