Aliso Kids Dental & Orthodontics
Pediatric Health History

Has your child had any of the following problems: *Please circle yes or no (do not leave blank)*:

Allergies to drugs or medications …	**YES NO**	**Hemophilia ……**	**YES NO**
Anemia ……..…	**YES NO**	**Hepatitis ..……**	**YES NO**
Asthma ……	**YES NO**	**High blood pressure ……..**	**YES NO**
Autism……..……..	**YES NO**	**High fevers …….……**	**YES NO**
Behavior problems …..……..	**YES NO**	**HIV+ / AIDS …...……**	**YES NO**
Birth defects ……..…	**YES NO**	**Kidney disease ……**	**YES NO**
Cancer or tumors……...	**YES NO**	**Learning disability ……**	**YES NO**
Cerebral Palsy ……	**YES NO**	**Liver disease …….. **	**YES NO**
Convulsions ……...…..	**YES NO**	**Nutritional problem …….. **	**YES NO**
**Diabetes ……... **	**YES NO**	**Mental retardation ……**	**YES NO**
**Ear infection ……..…….. **	**YES NO**	**Rheumatic / Scarlet fever …….**	**YES NO**
Epilepsy ……..…..	**YES NO**	**Sickle Cell Anemia ……**	**YES NO**
Prolonged bleeding……..…..……	**YES NO**	**Speech problems ……**	**YES NO**
Fainting / dizziness ……..…	**YES NO**	**Tonsillitis……..…….. **	**YES NO**
Handicaps / disabilities ……	**YES NO**	**Tuberculosis …….. **	**YES NO**
Hearing problems … ……	**YES NO**	**Vision problems ……**	**YES NO**
Heart trouble ……..	**YES NO**	**Latex Allergy …… **	**YES NO**
***Heart Murmur ……..... **	**YES NO**	**(*If yes, please provide a cardiologist release form)**	

Any special problems not listed above? _____

_____

Please list all medications that your child is <u>currently</u> taking _____

Is your child currently under the care of a physician? (routine or otherwise) YES NO

Describe _____

Physician name and phone number _____

Are immunizations up to date? YES NO

Were there any problems during pregnancy, delivery, or during the first year of your child's life? YES NO

Describe _____

<u>Dental History</u>

Has your child had any of the following problems: *Please circle yes or no (do not leave blank)*:

Lip sucking / biting habits.….	**YES NO**	**Any problems with previous dental work**	**YES NO**
Nail biting habits.….	**YES NO**	**Describe** _____	
Thumb / finger sucking habits.….	**YES NO**	**Hospitalization …… **	**YES NO**
Nursing bottle habits	**YES NO**	**Injuries to face, mouth, or teeth**	**YES NO**
Pain or tenderness in the jaw (TMJ) …..	**YES NO**	**Describe** _____	

<u>PREVIOUS DENTIST INFORMATION:</u> Name: _____ **Phone:** _____

Please read carefully initial, sign and date the following statements. Thank you.

1. **I understand the above information is necessary to provide my child with the dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. Initial _____**
2. **I hereby authorize doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my child's dental needs. Initial _____**
3. **I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with Initial _____ (Name of the patient) _____.**
4. **I understand that all responsibility for payment for dental services provided in this office for my child is mine, due and payable at the time services are rendered unless other arrangements have been made. In the events payments are not received by the agreed upon dates, I understand that a 1 ½ percent finance charge (18% APR) may be added to my account, in addition to any collection charges. Initial _____**
5. **I understand that where appropriate, credit bureau reports may be obtained. Initial _____**
6. **I understand that it is my responsibility to advise the office of any changes in the information contained on this form.**

Parent or responsible party _____ **Date** ____/____/____

Relationship to the child _____

Do not sign until asked. Updated Information is true and correct:

Parent's Signature _____ **Date** ____/____/____ Doctor's Signature _____

Parent's Signature _____ **Date** ____/____/____ Doctor's Signature _____