



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

1808 Verdugo Boulevard
Suite 312
Glendale, California
91208
818 • 790 • 6721

CHILD'S DENTAL HISTORY



Member
American Academy
of Pediatric Dentistry

California Society
of Pediatric Dentistry

American Board
of Pediatric Dentistry

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: _____

	Yes	No	<i>Please explain any YES answer</i>
1. Has child ever had dental radiographs (x-rays)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Has child ever reacted unfavorably to dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Has child had an allergic reaction to local anesthesia (Novocain, Lidocaine, Citanest)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Has child ever been a habitual thumb-sucker? Finger-sucker? Pacifier?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Did child have bottle past one year? To what age?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Does child have full charge of his /her own tooth brushing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Have you observed or been previously advised that orthodontic treatment is necessary?	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Is child a heavy "sweets" eater? How many times a day does he eat sugar?	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Has child ever suffered a severe blow to the teeth, face, or head?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Has child ever suffered from a high fever?	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Has child ever been treated for any gum disease (e.g. gingivitis, juvenile periodontitis, pyorrhea, trench mouth)	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Does child's gum bleed when brushing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Does child grind or clench teeth?	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Has your child taken fluoride vitamins or drops in the past? What age?	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Does your child currently take a fluoride supplement?	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. What is the name of the water company which you pay your water bill?	<input type="checkbox"/>	<input type="checkbox"/>	_____

CHILD'S MEDICAL HISTORY

HISTORY

- | | Yes | No | REVIEWER COMMENTS |
|---|--------------------------|--------------------------|-------------------|
| 1. Is your child being treated by a physician at this time? If yes, why? _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Has your child ever been a patient in a hospital? If yes, why? _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Has your child ever received general anesthesia or sedation? If yes, when? _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Is your child allergic to anything? (Medicine, food) If yes, what? _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Is your child taking a medication at this time? If yes, when? _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Has your child ever had a serious illness or operation? If yes, for what? _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 7. Has your child ever had a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 8. Does your child smoke or use tobacco products? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

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 | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Blood - Circulatory | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal - Stomach | <input type="checkbox"/> | <input type="checkbox"/> | Muscles |
| <input type="checkbox"/> | <input type="checkbox"/> | Bones | <input type="checkbox"/> | <input type="checkbox"/> | Kidney - Bladder | <input type="checkbox"/> | <input type="checkbox"/> | Nervous System |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine Glands | <input type="checkbox"/> | <input type="checkbox"/> | Heart | <input type="checkbox"/> | <input type="checkbox"/> | Skin |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes, Ears, Nose, Throat | <input type="checkbox"/> | <input type="checkbox"/> | Liver | <input type="checkbox"/> | <input type="checkbox"/> | Tonsils / Adenoids |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory - Lungs | | | | | | |
| <input type="checkbox"/> 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 | |
|--|--------------------------|-----------------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS (Immunosuppressive Disorder) | <input type="checkbox"/> | <input type="checkbox"/> | Eye Problems | <input type="checkbox"/> | <input type="checkbox"/> | Premature Birth |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding Problem | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergy | <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fevers |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain Injury | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis - Type _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Snoring at Night |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Sore Throats - Frequent |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> | Measles | <input type="checkbox"/> | <input type="checkbox"/> | Spina Bifida |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken Pox | <input type="checkbox"/> | <input type="checkbox"/> | Mental Retardation | <input type="checkbox"/> | <input type="checkbox"/> | Syndrome _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cleft Lip/Palate | <input type="checkbox"/> | <input type="checkbox"/> | Mumps | <input type="checkbox"/> | <input type="checkbox"/> | Tetanus |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Mouth Breathing | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Nutritional Deficiency | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Diphtheria | <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic Problems | <input type="checkbox"/> | <input type="checkbox"/> | Whooping Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Abuse | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | Polio | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> 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 preceding 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 appointment.

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 perform 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 _____