



Pediatric Dentistry San Ramon

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Child's name: _____ Nickname: _____ Sex: (M) (F)

Purpose of visit: _____ Concerns: _____ Birthdate: _____

Name and age of brothers/sisters: _____ Is your child adopted? Y N

Child's Interests: _____ Name of Pet(s): _____

Does your child have any special needs? _____ Any phobias? _____

Child's learning: slow average accelerated Child's school: _____

Who may we thank for referring you to us? _____

Health History

Child's Pediatrician: _____ Phone number :_(_____)_____ Last Physical: _____

Is your child under a physician's care now? Y N If yes, reason: _____ Immunization up to date? Y N

Is your child taking any medications currently (including over the counter)? Y N If yes, please list: _____

Is your child allergic to any medication? Y N If yes, please list: _____

Any history of hospitalization or surgery: (if yes, when) _____

Does your child have allergic reaction to: (if yes: please check all that applies)

Peanuts/ Tree nuts Soy Latex/ Rubber Pollen/ Dust/ Environmental Anesthetics
 Eggs Metals Animals Berries Acrylic
 Milk Wheat/Gluten Dyes/Coloring Others: _____

Has your child had a history or difficulty with any of the following?

ADHD/ADD	Y N	Cardiac Disease/Heart	Y N	Hepatitis	Y N
Anemia	Y N	Cerebral Palsy	Y N	Immune Disorder	Y N
Allergies	Y N	Chemo/Radiation Therapy	Y N	Kidney	Y N
Arthritis/Joint Disorder	Y N	Cystic Fibrosis	Y N	Liver	Y N
Asthma	Y N	Delayed Development	Y N	Murmur	Y N
Allergies to Medications	Y N	Depression/Anxiety	Y N	Muscular Disorder	Y N
Autism	Y N	Diabetes	Y N	Premature Birth	Y N
Bladder	Y N	Down's Syndrome	Y N	Rheumatic Fever/Heart	Y N
Bleeding Disorder	Y N	Earaches/Infections	Y N	Speech Disorder	Y N
Bone Disorder	Y N	Eating Disorder	Y N	Sinusitis	Y N
Brain Injury	Y N	Emotional/School Problems	Y N	TMJ Problems	Y N
Bruising	Y N	Epilepsy/Seizure	Y N	Tuberculosis	Y N
Cancer/Malignancy	Y N	Hearing Impaired	Y N	Visual Impaired	Y N

Other: _____

Dental History

Is this your child's first dental visit? Y N If no, previous dentist: _____ Phone number:_(_____)_____

Date of last visit: _____ How was his/her experience? _____ Were any x-rays taken? Y N

Child's attitude towards the dentist or dental care: _____

Has your child had any injuries to teeth, mouth, or head? Y N If yes, please describe: _____

Has your child done any of the following (past or present)?

Please circle: thumb/finger-sucking pacifier nail biting lip sucking mouth-breathing snoring teeth grinding nursing bottle-feeding

