



Santa Margarita Pediatric Dentistry

Plaza Empresa
29941 Aventura IC
Rancho Santa Margarita, CA 92688
(949) 858-5150

Date _____

PATIENT HISTORY RECORD

Child's Name _____ Nickname _____ M F
Age _____ Date of Birth _____ School _____ Grade _____
Reason for this visit _____
Referred to our office by _____

MEDICAL HISTORY

Child's Physician _____ City _____
Date last saw physician: Month _____ Year _____

	Yes	No
1. Is your child presently under the care of a physician for any medical problem or condition?	<input type="checkbox"/>	<input type="checkbox"/>
What? _____		
2. Is your child currently taking any medication?	<input type="checkbox"/>	<input type="checkbox"/>
What? _____ Dosage _____		
3. Does your child have a history of:		
<input type="checkbox"/> heart trouble or murmurs	<input type="checkbox"/> rheumatic fever	<input type="checkbox"/> allergies
<input type="checkbox"/> drug sensitivity	<input type="checkbox"/> diabetes	<input type="checkbox"/> asthma
<input type="checkbox"/> epilepsy	<input type="checkbox"/> seizures or convulsions	<input type="checkbox"/> kidney or liver involvement
<input type="checkbox"/> hepatitis	<input type="checkbox"/> bleeding problems	<input type="checkbox"/> blood disorders
<input type="checkbox"/> brain injury	<input type="checkbox"/> other: _____	
4. Has your child ever been hospitalized or had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
For what? _____ When? _____		
5. Is your child emotionally disturbed or have any learning disabilities?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is there any other medical history or problem you feel should be brought to the doctor's attention?	<input type="checkbox"/>	<input type="checkbox"/>
What? _____		

DENTAL HISTORY

1. Is this your child's first dental visit?

	<input type="checkbox"/>	<input type="checkbox"/>
Previous Dentist? _____ City _____ Date of last visit _____		
2. Has your child had an unfavorable experience in a previous dental (or medical) office?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have there been any injuries to your child's teeth or jaws? (falls, blows, chips, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child receive fluoride vitamins, tablets, water, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has your child been seen by an orthodontist?	<input type="checkbox"/>	<input type="checkbox"/>
6. Name of Parent's Dentist: _____ City _____		

FAMILY RECORD

Residence Address _____ City _____ Zip _____
Residence Phone _____ Fax # _____ E-mail _____
Father's Full Name _____ Birthdate _____ SS # _____
 Address (if different) _____
 Occupation _____ Employed by _____
 Bus. Address _____ City _____ Bus. Phone _____
Mother's Full Name _____ Birthdate _____ SS # _____
 Address (if different) _____
 Occupation _____ Employed by _____
 Bus. Address _____ City _____ Bus. Phone _____
Please list the first names of all brothers and sisters and their ages: _____

Has any member of your family been a patient in this office before?

	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please name _____		

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

1. Is your child covered by a dental insurance plan?

	<input type="checkbox"/>	<input type="checkbox"/>
Name of Parent insured _____ SS# _____ Driver's Lic. # _____		
Name of insurance _____ Group No. or Policy No. _____		
Has your child received previous dental care under this plan?	<input type="checkbox"/>	<input type="checkbox"/>
2. Legal Guardian(s): _____		
3. If family is not living together, person to be responsible for child's account: _____		

I hereby authorize Drs. Jeffery Brown, Loretta Chee, Carol Yeung and/or their associates to perform any and all treatment for my above named child and consent to such methods, drugs and agents as may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled.

SIGNATURE _____ RELATIONSHIP TO CHILD _____ DATE _____

PLEASE NOTE: PAYMENT IS EXPECTED FOR SERVICE RENDERED AT THE TIME OF THE FIRST VISIT. FINANCIAL ARRANGEMENTS FOR SUBSEQUENT TREATMENT MAY BE MADE FOLLOWING THE DIAGNOSIS.