Santa Margarita
PEDIATRIC DENTISTRY
Serving the RSM Area For Over 20 Years

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?	❑	❑
What? _____		
2. Is your child currently taking any medication?	❑	❑
What? _____ Dosage _____		

3. Does your child have a history of:

❑ heart trouble or murmurs	❑ rheumatic fever	❑ allergies
❑ drug sensitivity	❑ diabetes	❑ asthma
❑ epilepsy	❑ seizures or convulsions	❑ kidney or liver involvement
❑ hepatitis	❑ bleeding problems	❑ blood disorders
❑ brain injury	❑ other: _____	

4. Has your child ever been hospitalized or had surgery?	❑	❑
For what? _____ When? _____		
5. Is your child emotionally disturbed or have any learning disabilities?	❑	❑
6. Is there any other medical history or problem you feel should be brought to the doctor's attention?	❑	❑
What? _____		

DENTAL HISTORY

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

FAMILY RECORD

Residence Address _____ City _____ Zip _____
Residence Phone _____ Cell Phone # _____ 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?	❑	❑
If yes, please name _____		

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

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

2. Legal Guardian(s): _____
3. If family is not living together, person to be responsible for child's account: _____

I hereby authorize Drs. Jeanne Nguyen, Jeff Staples, John Fowle 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.