MURRIETA CHILDREN'S DENTISTRY

A DENTAL GROUP OF KIM, KIM & NGUYEN DDS, DENTAL CORP.

PATIENT INFORMATION

This confidential information is of great value in helping us to better understand and treat your child.

REASON FOR VISIT / CHIEF COMPLAINT Date ___/___/___

_____

_____

_____

SS# _____

Child's name _____ Nickname _____ Sex M F

Age_____ Birthdate ___/___/___ School _____ Grade _____

Name & age of brothers _____

Name & age of sisters _____

Child's address _____ City _____ Zip _____

Residence phone ( ) _____

Nearest relative not living with child _____

Address _____ Phone ( ) _____

Parent 1 _____	Parent 2 _____
Parent's date of birth ___/___/___	Parent's date of birth ___/___/___
Parent's Social Security # _____	_____
Driver's License # _____	Driver's License # _____
Occupation _____	Occupation _____
Parent's address _____	Parent's address _____
_____	_____
Home phone # ( ) _____	Home phone # ( ) _____
Parent's employer _____	Parent's employer _____
Work phone # ( ) _____	Work phone # ( ) _____
Employer's address _____	Employer's address _____
_____	_____

Father's Dental Insurance Co. _____ Group # _____

Dental Insurance Billing Address _____

Mother's Dental Insurance Co. _____ Group # _____

Dental Insurance Billing Address _____

Dual Insurance _____ Yes _____ No

Child's Primary Dental Insurance _____

Child's Secondary Dental Insurance _____

Does the child have Medi-Cal or Denti-Cal? _____ Yes _____ No

Whom may we thank for referring you to our office? _____

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY

Child's physician _____ City _____ Phone # ( )_____

Date of last physical exam ___/___/___

Is your child presently under the care of a physician for any medical problem? YES NO

If so, for what problem? _____

Is your child currently taking any medication? YES NO

Medicine _____ Dosage _____

Has there been any change in his/her health within the past year? YES NO

Is your child sensitive or allergic to any drugs (e.g. penicillin)? YES NO

Does your child have a history of allergies (Latex allergies)? YES NO

Does your child bruise easily? YES NO

Has your child ever been hospitalized or had surgery? YES NO

Reason? _____ Date ___/___/___

Has your child ever had blood transfusions? YES NO

If so, for what reason and when? _____

Is your child emotionally disturbed, developmentally delayed, handicapped, or have a learning disability? YES NO

Has your child had a history of?

Heart trouble or murmur	YES	NO	Heart or neck pain	YES	NO
Rheumatic fever	YES	NO	Glaucoma	YES	NO
Diabetes	YES	NO	Skin disorders, Rashes, Hives	YES	NO
Tuberculosis	YES	NO	Respiratory problems	YES	NO
Anemia	YES	NO	Bleeding problems	YES	NO
Arthritis or joint disease	YES	NO	Autism	YES	NO
Asthma	YES	NO	Developmental delays	YES	NO
Blood Disorder	YES	NO	Behavioral/Learning problems	YES	NO
Bone Disorder	YES	NO	Thyroid problems	YES	NO
Cancer	YES	NO	Ulcers or stomach problems	YES	NO
Congenital birth defects	YES	NO	Seizure disorder, Convulsions	YES	NO
Epilepsy	YES	NO	Neurological problems	YES	NO
Kidney/Bladder problems	YES	NO	HIV Virus or AIDS	YES	NO
Hepatitis or Jaundice	YES	NO	Hearing/Sight problems	YES	NO
Stroke	YES	NO	Trauma	YES	NO

Any other conditions or problems that the doctor should be aware of?_____

DENTAL HISTORY

Is this your child's first dental visit? YES NO

Previous Dentist _____ City _____ Date of last visit ___/___/___

Has your child had an unfavorable experience at another office? YES NO

How do you think your child will act toward the dentist? _____

How many times per day does your child brush his/her teeth? _____ Is dental floss used? YES NO

Is fluoride taken in any form? (water, tablets, etc.) YES NO

Does your child have a history of finger sucking _____ lip sucking _____ nail biting _____ pacifier____?

How old was your child when he/she discontinued bottle use or nursing? _____

Does your child have a problem with his/her bite? YES NO

I hereby state the above information is true and correct.

Print name _____ Relation to child _____ Date ___/___/___

Signature _____ Dr. Signature _____ Date ___/___/___