Urmi Amin, DDS MS
10 El Camino Real, Suite 102
San Carlos, CA 94070
Phone: (650) 596-8045 Fax: (650) 596-8074

Patient's Name: _____ Date of Birth: ___ /___/_____

Parent / Guardian Name: _____

1. Your Child's Physician Information:

   Name: _____

   Address: _____

   Phone Number: _____

   Date of Last Medical Visit: _____

2. Is your child taking any medication(s)? ☐ Yes ☐ No ☐ Don't Know
   If yes, list_____
   _____
3. Is your child allergic to any medication, anesthetic solutions, latex, or foods?
   ☐ Yes ☐ No ☐ Don't Know
   If yes, list _____
4. Has your child had a serious illness? ☐ Yes ☐ No ☐ Don't Know
   When_____ What_____
5. Has your child ever had surgery? ☐ Yes ☐ No ☐ Don't Know
   Has your child ever been treated in the emergency room? ☐ Yes ☐ No ☐ Don't Know
   List age and reason_____
6. Does your child have any history of:
   - Heart murmurs? ☐ Yes ☐ No ☐ Don't Know
   - Rheumatic Fever? ☐ Yes ☐ No ☐ Don't Know
   - Blood or bleeding disorders? ☐ Yes ☐ No ☐ Don't Know
   - Birth defects or genetic disorders? ☐ Yes ☐ No ☐ Don't Know
   - Growth or developmental disorders? ☐ Yes ☐ No ☐ Don't Know
   - Convulsions, fainting or seizures? ☐ Yes ☐ No ☐ Don't Know
   - Cerebral palsy? ☐ Yes ☐ No ☐ Don't Know
   - Ear, nose, or throat problems? ☐ Yes ☐ No ☐ Don't Know
   - Hearing problems? ☐ Yes ☐ No ☐ Don't Know
   - Speech or vision problems? ☐ Yes ☐ No ☐ Don't Know
   - Childhood diseases such as chicken pox, mumps, measles or Scarlet Fever? ? ☐ Yes ☐ No ☐ Don't Know
   - Tuberculosis? ☐ Yes ☐ No ☐ Don't Know
   - Other medical conditions? ☐ Yes ☐ No ☐ Don't Know
   - Ever had Phen-Fen or Bisphosphorate? ☐ Yes ☐ No ☐ Don't Know

DENTAL HISTORY
PATIENT INFORMATION

1. Is this your child's first visit to the dentist? ☐ Yes ☐ No ☐ Don't Know
   a. If not, how long since the last visit to the dentist?_____
   b. Were any x-rays taken at that time? ☐ Yes ☐ No ☐ Don't Know
2. Does your child eat between meals? ☐ Yes ☐ No ☐ Don't Know
3. Does your child eat sweets/soda? ☐ Yes ☐ No ☐ Don't Know
4. When does your child brush his/her teeth?
   __Upon rising __After eating any food __Right after meals
   __Before going to bed
5. Does your child take fluoride? ☐ Yes ☐ No ☐ Don't Know
6. Has your child ever had any of the following dental problems
   a. Injuries to the mouth? ☐ Yes ☐ No ☐ Don't Know
   b. Toothaches or abscesses? ☐ Yes ☐ No ☐ Don't Know
7. Does your child have any of the following habits?
   a. Finger, thumb, or pacifier sucking? ☐ Yes ☐ No ☐ Don't Know
   b. Tooth grinding or clenching ☐ Yes ☐ No ☐ Don't Know
   c. Mouth breathing ☐ Yes ☐ No ☐ Don't Know
8. Has anyone in the family, including parents had orthodontics? Yes No Don't Know
9. Has your child ever had sealants? ☐ Yes ☐ No ☐ Don't Know

SOCIAL AND BEHAVIOUR HISTORY

1. Do you think that your child will cooperate for dental treatment? ☐ Yes ☐ No ☐ Don't Know
2. Has your child had a bad or fearful dental or medical experience? ☐ Yes ☐ No ☐ Don't Know
3. Has your child had any history of emotional or behavioral problems? ☐ Yes ☐ No ☐ Don't Know
4. Is your child adopted? ☐ Yes ☐ No ☐ Don't Know
5. Name and age of siblings_____
   _____
6. Which of the following best describes your child?
   a. ____Advanced in learning process
   b. ____Progressively normal
   c. ____Slow learner
7. Is there any additional information we should know? ☐ Yes ☐ No ☐ Don't Know

To the best of my knowledge, the above information is correct.

_____ _____ _____
Signature of parent/guardian completing form Date Relationship to child