Victor Valley

Kids Dental

Child's Name:___________________________

DENTAL HISTORY

Former Dentist: Date of last exam:

Date of last x-rays:

Reason for Today's Visit: ☐ Exam ☐ Emergency ☐ Consultation

How Often Does Your Child Brush? How Often Does Your Child Floss?

Please check any of the following conditions that apply to your child:

☐ Bad Breath
☐ Bleeding Gums
☐ Clicking or Popping Jaw
☐ Food Collection Between Teeth
☐ Grinding Teeth
☐ Loose teeth or broken fillings
☐ Sensitive to Cold
☐ Sensitivity to Heat
☐ Sensitivity to Sweets
☐ Sores or growths in mouth
☐ Thumb sucking
☐ Nail Biting

MEDICAL HISTORY

Child's Physician: Date of Last Visit:

Address: Phone Number:

Is Child taking any of the following medications? ☐ Pain Killers(including Aspirin) ☐ Ritalin

☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Muscle Relaxers ☐ Other:

Has the child ever been diagnosed with or treated for any of the following conditions?

Yes☐ No☐ Heart Murmur
Yes☐ No☐ Rheumatic Fever
Yes☐ No☐ Artificial Heart Valves
Yes☐ No☐ Congenital Heart Defect
Yes☐ No☐ Scarlet Fever
Yes☐ No☐ Surgeries/Operations
Yes☐ No☐ Chemotherapy
Yes☐ No☐ Jaw Problems/TMJ
Yes☐ No☐ Hearing Problems
Yes☐ No☐ Hearing Problems
Yes☐ No☐ Heart Problems

Yes☐ No☐ Tonsillitis
Yes☐ No☐ Respiratory Problems
Yes☐ No☐ Asthma/Difficulty Breathing
Yes☐ No☐ Blood Transfusion
Yes☐ No☐ Leukemia
Yes☐ No☐ Anemia
Yes☐ No☐ Diabetes/Hypoglycemia
Yes☐ No☐ Hemophilia
Yes☐ No☐ Abnormal Bleeding
Yes☐ No☐ Cleft Lip/Palate
Yes☐ No☐ Autism/Autism Spectrum

Yes☐ No☐ Birth Defects
Yes☐ No☐ High/Low Blood Pressure
Yes☐ No☐ Hepatitis
Yes☐ No☐ Artificial bones/joints
Yes☐ No☐ Liver/kidney Organ Problems
Yes☐ No☐ HIV/AIDS/ARC
Yes☐ No☐ Tuberculosis TB
Yes☐ No☐ ADD/ADHD
Yes☐ No☐ Seizures/Epilepsy
Yes☐ No☐ Cerebral Palsy

List any operations/surgeries:____

Allergic to:
Yes☐ No☐ Latex
Yes☐ No☐ Penicillin/Amoxicillin
Yes☐ No☐ Aspirin
Yes☐ No☐ Tetracycline
Yes☐ No☐ Dental Anesthetics
Yes☐ No☐ Food Allergies
Other:___________________________

Has your child every taken Phen fen?: Yes☐ No☐

Are there any other special conditions not listed that your child has/ever had:_______________________

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I affirm that the information I gave on this form is correct to the best of my knowledge and is my responsibility to inform this office of any changes in the child's medical status. I authorize my insurance benefits to be paid directly to Victor Valley Kids Dental and I understand that I am responsible for the payment of deductibles, co-payments and any balances not covered by my insurance. I also authorize Victor Valley Kids Dental to release any information required to process the child's claims. I understand that payment is due at the time of service.

_______________________________ _______________________________

Dr. Signature Date Signature of Parent/Legal guardian Date