stellar Kids Dentistry

Today's date: _____

New Patient Medical/ Dental History

Child's Name: _____ Preferred Name: _____

Date of birth: _____ ☐ Male ☐ Female Lives with: Mother ___ Father ___ Grandparents ___

Foster Parents ___ Other _____

Name of person completing this form: _____ Relationship to Patient: _____

Child's Physician: _____ Physician's Phone: _____

Medical History: (Please fill out completely)

- ☐ Sickle Cell Anemia or Trait (describe) _____
- ☐ Blood disorder or anemia (describe) _____
- ☐ Bruises easily
- ☐ Blood Transfusions
- ☐ Tonsillectomy and/or adenoidectomy
  When _____
- ☐ Heart Condition
- ☐ Heart Murmur (Innocent or Pathologic)
- ☐ High/Low Blood Pressure
- ☐ Cystic Fibrosis
- ☐ Scarlet Fever
- ☐ Asthma
  Frequency _____ Meds_____
- ☐ Thyroid Disorder
- ☐ Measles, Mumps, Chicken Pox
- ☐ Malignant Hyperthermia
- ☐ Skin Disease - Eczema
- ☐ Hepatitis Type _____
- ☐ Chronic Ear Infections/Otitis Media (describe)
- ☐ Tuberculosis or Positive Result (When _____)
- ☐ Stomach or GI disorder (describe) _____
  G-tube? _____
- ☐ Is the patient or a parent pregnant
- ☐ Diabetes (describe) _____
- ☐ Cancer (describe) _____
- ☐ Seizure Disorder (describe) _____
- ☐ Learning Disability (describe) _____
- ☐ Autism Spectrum Disorder (describe) _____
- ☐ Neurologic Disorder/Hydrocephalus/Muscle Weakness
- ☐ ADD/ADHD/Hyperactivity (describe) _____
- ☐ Down's Syndrome (Mild, Moderate, Severe)
- ☐ Depression
- ☐ Anxiety
- ☐ Body Image issues
- ☐ Cerebral Palsy, Muscular Dystrophy
- ☐ Tuberculosis or Positive Result
  When _____
- ☐ Kidney Disease or Transplant
- ☐ Handicaps or disabilities: _____
- ☐ AIDS/HIV
- ☐ Joint Replacement
- ☐ Frequent headaches
- ☐ Cold sores.

Is your child currently taking any medications?	☐ Yes	☐ No	List:
Does your child have allergies?	☐ Yes	☐ No	List:
Is your child allergic to any medications?	☐ Yes	☐ No	Explain:
Hospital stays or significant injuries In the last 12 months?	☐ Yes	☐ No	List:
Is your child under care for any other conditions?	☐ Yes	☐ No	Explain:
Is your child's immunization record current?	☐ Yes	☐ No	

Dental History: (Please fill out completely)

Has your child ever experienced the following dental problems? Check all that apply.

- ☐ Speech problems / delay
- ☐ Grinding
- ☐ Broken teeth
- ☐ Stained or discolored teeth
- ☐ Dental infection / abscess
- ☐ Pain from teeth
- ☐ Past injury of trauma to teeth, mouth, lips
- ☐ Popping or soreness of jaws
- ☐ Has your child been prescribed Fluoride supplements in the past or is currently using? _____ Yes _____ No

Was your child bottle fed / breast fed and for how long? _____

Does / Did your child suck a thumb, finger, pacifier? (describe) _____

Has your child ever been diagnosed with Cleft Lip/Palate? ____ Yes ____ No

How does your child do for doctors / hair cut appointments _____

Has your child had extensive dental treatment in the past? (describe) _____

Previous Dentist? _____ City/ State _____

Were radiographs taken at this visit? ____ Yes ____ No _____ Don't know

Comments or Anything you would like to discuss today:

_____

_____

_____

Signature

AUTHORIZATION: I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Since my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental service can be started. I grant Dr. Sonu Lamba, Dr. Paul Kahlon, and their trained staff consent to do an oral exam, take appropriate x-rays, clean the teeth, give a Fluoride treatment, and provide oral hygiene instructions, as deemed appropriate. I understand I will be consulted before another treatment is rendered. I understand that this information will be used by our dentists to help determine the appropriate and ideal dental treatment. If there is any change in my child's medical status, I will inform the office immediately.

I authorize the insurance company that I have provided the information for to pay Stellar Kids Dentistry all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Stellar Kids Dentistry to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date:_____

Relationship to the patient: _____