Alameda Pediatric Dentistry & Orthodontics

Alameda (510) 521-5437 • Pleasanton (925) 846-5437 • Oakland (510) 763-5437 • Brentwood (925) 516-4107

HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Today's Date: _____

DENTAL HISTORY

Is/was your child breast-fed and/or bottle-fed? (Please circle) | Until age: _____
Does your child drink juices/sweetened drinks? Yes □ No □ If yes, what kind: _____
Does your child take any enhanced formula or fluoride supplements? Yes □ No □ Describe: _____

How often does your child brush their teeth? _____ What toothpaste do they use? _____
Does your child floss daily? Yes □ No □ Does an adult assist with the brushing and/or flossing? Yes □ No □
How do you think your child will react to dental treatment? _____
Has your child had any injuries to teeth, mouth, face, or head? If yes, please describe: _____

Has your child had any of the following habits (past or present)? If yes, please circle:

Cheek Biting	Pacifier	Lip Sucking	Jaw Clenching	Snoring
Thumb Sucking	Nail Biting	Teeth Grinding	Mouth Breathing	Tongue Thrust

Is there clicking, popping, or discomfort in the jaw joints? Yes □ No □ If yes, when did it begin: _____

MEDICAL HISTORY

Current Age: _____ Height: _____ Weight: _____
Has your child ever been hospitalized or had a major operation? Yes □ No □ If yes, describe: _____
Are your child's immunizations up to date? Yes □ No □ If no, reason: _____
Is your child taking any medications or drugs? Yes □ No □ If yes, list: _____
Is your child sensitive or allergic to any drug(s), food(s), latex products, or other materials? Yes □ No □
If yes, describe: _____
Child's Pediatrician: _____ Date of Last Visit: _____
Pediatrician Location/Address: _____ Phone #:_____

Has your child ever been diagnosed as having any of the following? If yes, please circle:

ADD and/or ADHD	Congenital Disorders	Hepatitis
AIDS and/or HIV+	Currently Pregnant	High / Low Blood Pressure
Artificial Joints or Limbs	Cystic Fibrosis	Kidney Problems
Asthma / Breathing Problems	Developmental Delay	Liver Problems
Autism Spectrum Disorder	Diabetes Type 1 or Type 2	Nutritional Deficiency
Bone Conditions	Eating Disorders	Oral Ulcers
Blood Disorders	Emotional Problems	Premature Birth
Cancer or Malignancies	Endocrine Conditions	Rheumatic Fever
Cerebral Conditions	Epilepsy or Seizures	Sinus Problems
Chemotherapy / Radiation	Excessive Gagging	Skin Problems
Chronic Adenoid/Tonsil Infection	Frequent Infections	Sleep Apnea
Chronic Ear Infections	Gastrointestinal Issues	Speech Impediment
Chronic Headaches or Migraines	Hearing Impaired	TMJ Disorder
Cleft Lip / Palate	Heart Conditions	Tuberculosis

Any Other Dental or Health Concerns: _____

To the best of my knowledge, the questions on this form have been answered with accuracy. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in health.

Parent/Guardian Name (Print): _____ Signature: _____

CLINICAL USE ONLY Reviewed by: _____