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? Yes☐No☐ If yes, Please describe:
_____
Has your child had any of the following habits (past or present)? If yes, please select:

☐ 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 select:

☐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: _____