HAPPY HEALTHY TEETH
pediatric dentistry & orthodontics

• WELCOME •

tell us about your child

Child's Name: _____ Nickname: _____
First Middle Last

Sex: Male: ◯ Female: ◯ Birth Date: _____ Age: _____ Guardianship: Parent: ◯ Adopted: ◯ Legal: ◯

Home address: _____ City: _____ Zip Code: _____

Names and ages of brothers and sisters: _____

Has any member of your family been a patient of Dr. Lee's in the past? Yes: ◯ No: ◯ Name(s): _____

Whom may we thank for referring you to our office? _____

Address: _____ Telephone: _____

Please list your child's interests and hobbies:

a) _____ d) _____
b) _____ e) _____
c) _____ f) _____

What prompted you to phone our office?

What do you hope to accomplish from your meeting with us?

What things, from previous dental experiences, would you like to find in our office?

What experiences would you hope to avoid or eliminate?

Are there any problems, issues or challenges you would like us to help you with? Please explain.

What should we know about you in order to work most effectively with you and your family?

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general information

Person responsible for this account: Parent 1: ◯ Parent 2: ◯ Other: ◯ _____

Do parent 1, parent 2 and child live together? Yes: ◯ No: ◯ If No, Please Explain: _____

Parent 1 full name: _____ Birthdate (MM/DD/YYYY): _____

Driver's License or ID#: _____ State: _____

Relationship to patient: _____ Martial Status: _____

Home address: _____ City: _____ Zip Code: _____

Home tel: _____ Cell: _____ E-mail: _____

Employer: _____ Occupation: _____ How long with present firm: _____

Wk address: _____ Wk Tel: _____

Parent 2 full name: _____ Birthdate (MM/DD/YYYY): _____

Driver's License or ID#: _____ State: _____

Relationship to patient: _____ Martial Status: _____

Home address: _____ City: _____ Zip Code: _____

Home tel: _____ Cell: _____ E-Mail: _____

Employer: _____ Occupation: _____ How long with present firm: _____

Wk address: _____ Wk Tel: _____

Person to notify in case of emergency: Name: _____ Relationship: _____

Home address: _____ Home Tel: _____

insurance information

Is your child covered by any dental insurance plan? Yes: ◯ No: ◯ If yes, please answer the following:

Name of primary dental plan: _____ Group Number: _____

1. Name of employee covered under primary plan: _____
2. His/her social security number: _____
3. Name of union and local number _____
4. Has the child had previous dental care under this plan? Yes: ◯ No: ◯

Name of secondary dental plan: _____ Group Number: _____

1. Name of employee covered under primary plan: _____
2. His/her social security number: _____
3. Name of union and local number _____
4. Has the child had previous dental care under this plan? Yes: ◯ No: ◯

Patient's Name: _____

• HEALTH HISTORY •

This information can be great value in aiding us to a better understanding of your child in providing dental health care.

medical

Name of family physician or pediatrician: _____ Date Of Last Exam: _____

Address: _____ Telephone: _____

Is your child in good health? Yes: ◯ No: ◯

Does your child have regular medical check-ups? Yes: ◯ No: ◯

Are your child's immunizations up to date? Yes: ◯ No: ◯

Is your child allergic to rubber latex or drug medications such as antibiotics or local anesthetics? Yes: ◯ No: ◯

Is your child allergic to anything else? Yes: ◯ No: ◯

If yes, please list and describe: _____

Is your child presently taking any medications? Yes: ◯ No: ◯

If yes, what type of medication(s) dose(s) and for what condition(s)?

_____

Is your child taking, has taken or is scheduled to begin taking: fenfluramine (pondimin), dexphenfluramine (redux), fenfluramine-phentermine combination (fen-phen), alendronate (fosamax), risedronate (actonel) or bisphosphonates (aredia or zometa)? Yes: ◯ No: ◯

If yes, what type of medication(s) dose(s) and for what condition(s)?

_____

Has your child ever been hospitalized or sustained significant injuries? Yes: ◯ No: ◯

If yes, why? _____

Does your child have autism, pervasive developmental disorder or autistic spectrum disorder? Yes: ◯ No: ◯

Do you consider your child to be high strung or nervous? Yes: ◯ No: ◯

Has your child had any history or difficulty with any of the following:

Premature Birth	Yes: ◯	No: ◯	Behavior Or Learning Problems	Yes: ◯	No: ◯
Birth Defects	Yes: ◯	No: ◯	Adverse Drug Reaction	Yes: ◯	No: ◯
Genetic Syndrome	Yes: ◯	No: ◯	Allergies	Yes: ◯	No: ◯
Bone Disorders	Yes: ◯	No: ◯	Heart Problems Or Murmur	Yes: ◯	No: ◯
Cancer	Yes: ◯	No: ◯	Mitral Valve Prolapse	Yes: ◯	No: ◯
Difficult First Year Of Life	Yes: ◯	No: ◯	Rheumatic Or Scarlet Fever	Yes: ◯	No: ◯
Frequent Infections	Yes: ◯	No: ◯	Bleeding Problems Or Bruising	Yes: ◯	No: ◯
Ear Infections	Yes: ◯	No: ◯	Anemia	Yes: ◯	No: ◯
Immune Disorders	Yes: ◯	No: ◯	Blood Transfusions	Yes: ◯	No: ◯
High Fever	Yes: ◯	No: ◯	Breathing Or Lung Problems	Yes: ◯	No: ◯
Convulsions/Seizures	Yes: ◯	No: ◯	Asthma	Yes: ◯	No: ◯
Epilepsy	Yes: ◯	No: ◯	Tuberculosis	Yes: ◯	No: ◯
Brain Injury	Yes: ◯	No: ◯	Diabetes Or Endocrine Problems	Yes: ◯	No: ◯
Recurrent Headaches	Yes: ◯	No: ◯	Eye Problems	Yes: ◯	No: ◯
Fainting, Dizziness Or Motion Sickness	Yes: ◯	No: ◯	Liver	Yes: ◯	No: ◯
Cerebral Palsy	Yes: ◯	No: ◯	Hepatitis	Yes: ◯	No: ◯
Mental Retardation	Yes: ◯	No: ◯	Gagging	Yes: ◯	No: ◯
Delayed Development	Yes: ◯	No: ◯	Gastric, Reflux Or Digestive Problems	Yes: ◯	No: ◯
Speech Or Hearing Problems	Yes: ◯	No: ◯	Kidney Or Bladder Problems	Yes: ◯	No: ◯
Attention Deficit Disorder	Yes: ◯	No: ◯	Other	Yes: ◯	No: ◯

If yes, please explain: _____

_____

dental

Give the date of your last dental exam or care and location: _____

Name of former dentist: _____

Address: _____ Telephone: _____

Has your child taken dental x-rays? ..... Yes: ◯ No: ◯

Has your child had any unfavorable reaction from any previous dental care? ..... Yes: ◯ No: ◯

If yes, please explain: _____

_____

Has mother or father had a lot of dental decay? ..... Yes: ◯ No: ◯

Is your child still nursing on the bottle or breast? ..... Yes: ◯ No: ◯

What is your child's primary water source (i.e., tap, filtered, bottled, etc)? _____

Has your child had any history of:

Fluoride Treatments	Yes: ◯	No: ◯	Pain	Yes: ◯	No: ◯
Thumb Sucking	Yes: ◯	No: ◯	Broken Teeth	Yes: ◯	No: ◯
Finger Sucking	Yes: ◯	No: ◯	Extracted Teeth	Yes: ◯	No: ◯
Lip Biting	Yes: ◯	No: ◯	Gum Infections	Yes: ◯	No: ◯
Nail Biting	Yes: ◯	No: ◯	Missing Permanent Teeth	Yes: ◯	No: ◯
Pacifier	Yes: ◯	No: ◯	Extra Permanent Teeth	Yes: ◯	No: ◯
Clenching Or Grinding	Yes: ◯	No: ◯	Injuries To Face, Mouth Or Teeth	Yes: ◯	No: ◯
Mouth Breathing	Yes: ◯	No: ◯	Orthodontics	Yes: ◯	No: ◯
Cavities	Yes: ◯	No: ◯	Jaw Pain, TMJ Or TMD History	Yes: ◯	No: ◯
Toothaches	Yes: ◯	No: ◯	Other	Yes: ◯	No: ◯

To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr(s). Lee, Yee or one of their associate or staff members of any change in the patient's health and/or medication.

Signature: _____ Date: _____

Parent or Guardian:

permission for dental treatment

I hereby give permission to Jonathon Everett Lee, D.D.S., Brian D. Lee, D.D.S., M.S.D., Christian P. Yee, D.D.S., and their respective associates and staff to render all necessary dental services and to use such methods and agents as they see fit for the child named on this form. I understand that no treatment will be started until recommended treatment, time involved, and financial investment has been discussed with me or my representative by either Drs. Lee, Lee, or Yee or one of their associates or staff members, at which time I may void this permission if I so choose. Furthermore, I will be responsible for any bills incurred on this child for dental treatment. I understand that this practice renders services in the best interest of the health of the patient, and makes no assumption that these services will be paid by the insurance company.

Signature: _____ Date: _____

Parent or Guardian:

For office use only: Date: _____ Check in: _____ DAU: _____ DDS: _____

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