



Reinaldo J. Negron, D.D.S., M.S.D.
Leticia Mendoza-Sobel, D.D.S.

1333 Grand Avenue
 Piedmont, California 94610
 510 652-2603 Fax: 510 652-4146
 www.piedmontpediatricdentistry.com

Please fill out both sides of this form as completely as possible.

This information will be of great value in aiding us to a better understanding of your child in providing utmost oral health care.

Child's Name _____ Nickname _____
 Sex: M _____ F _____ Birthdate _____ Adoption/Guardianship _____
 What is the reason for this visit? _____
 Is this your child's first dental visit? _____ Date of last visit _____ Purpose _____
 What is your child's attitude and behavior toward previous dental care? _____
 Name of child's pet _____ Child's interests _____
 What school or pre-school does your child attend? _____
 Name of family dentist _____ Child's previous dentist _____
 How did you hear about our office? _____

MEDICAL INFORMATION

Child's Pediatrician _____ Phone Number _____
 Date of last physical exam _____ Is your child under a doctor's care now? _____
 For what reason? _____
 Is your child taking any medication or drugs? _____ What kind? _____
 Reason _____
 Has your child ever been hospitalized? _____ When? _____
 Reason? _____
 Is your child allergic to any medications? _____ Please list _____
 Reaction _____
 Does your child have allergies to: food _____ animals _____ pollen _____ dust _____ latex _____
 Does your child have good physical coordination? _____
 Has your child's developmental milestones been attained? _____
 Are your child's immunizations up-to-date? _____
 Has your child had a **history** or **difficulty** with any of the following:

Yes	No		Yes	No		Yes	No	
_____	_____	High Fevers	_____	_____	Bleeding Problems	_____	_____	Hearing Difficulties
_____	_____	Premature Birth	_____	_____	Nosebleeds	_____	_____	Earaches (chronic)
_____	_____	Tuberculosis	_____	_____	Bruising	_____	_____	Gag Reflex
_____	_____	Heart Problems	_____	_____	Anemia	_____	_____	Motion Sickness
_____	_____	Rheumatic Fever	_____	_____	Hepatitis	_____	_____	Cancer Or Malignancies
_____	_____	Asthma	_____	_____	Brain Injury	_____	_____	Kidney Problems
_____	_____	Seizures	_____	_____	Bone Disorder	_____	_____	Reflux/Regurgitation
_____	_____	Diabetes	_____	_____	Cerebral Palsy	_____	_____	Fainting Or Dizziness
_____	_____	Immune Disorder/HIV/AIDS	_____	_____	Liver Problems	_____	_____	Speech Disorder
_____	_____	Mental/Physical Disabilities				_____	_____	Chronic Cough/Congestions

Comments/details _____ Reviewed Hx: _____
 Does your child have any phobias? _____ Any emotional or school problems? _____
 How would you describe your child's learning: Slow _____ Average _____ Accelerated _____

DENTAL INFORMATION

Was your child bottle fed? _____ Until what age? _____ or breast fed? _____ Until what age? _____

Does your child have any oral habits, such as: finger/thumb sucking _____ pacifier _____ nail biting _____

lip sucking _____ mouth breather _____ snoring _____ tooth grinding _____ other _____

Has your child ever had any injuries to the teeth, mouth or head? _____

If yes, please describe _____

Has your child taken fluoride? _____ In what form and when? _____

Does your child brush regularly? _____ Does an adult assist with the brushing? _____

Does your child use dental floss? _____ Does an adult assist with flossing? _____

Has either parent or child been treated orthodontically (braces)? _____

How would you expect your child to behave in our office? _____

Describe your child: Outgoing _____ Shy _____ Stubborn _____ Anxious _____ Frightened _____

How may we help to make this visit a positive experience for your child? _____

THANK YOU FOR COMPLETING THIS DETAILED INFORMATION SO WE MAY BECOME BETTER ACQUAINTED WITH YOUR CHILD.

GENERAL INFORMATION

This information is requested for financial and credit purposes.

Name of the person who is financially responsible for this child _____

FATHER (full name) _____ Date of birth _____ Marital Status _____

Home address _____ City/State _____ Zip _____ Home phone _____

Employer _____ Address _____ City _____ Business phone _____

Social Security Number _____ Driver's License Number _____

MOTHER (full name) _____ Date of birth _____ Marital Status _____

Home address _____ City/State _____ Zip _____ Home phone _____

Employer _____ Address _____ City _____ Business phone _____

Social Security Number _____ Driver's License Number _____

Child resides with: Both parents _____ Caregiver _____ Other _____

Name of nearest relative not living with you (relationship) _____

Address _____ City/Zip _____ Home phone _____ Work phone _____

DENTAL INSURANCE INFORMATION

FATHER: Name of Insurance Company _____ Group/Policy No. _____

Address _____ Union Local _____

MOTHER: Name of Insurance Company _____ Group/Policy No. _____

Address _____ Union Local _____

Assignment of Benefits: I hereby authorize payment directly to the above named dentists of the group dental benefits otherwise payable to me but not to exceed the charges shown on the claim. I understand that I am financially responsible for any charges not covered by this authorization.

Consent: I give the dentist permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child.

SIGNATURE: _____ Date _____

Relationship to child _____