Ontario Kids N Braces
3333 Concours St Bldg 6, Ste 201
Ontario CA, 91764
(909)466-4611

Pediatric Medical History Form

Date _____

Child's Information:
Patient Full Name_____
Nickname _____
Sex _____ Age _____ Date of Birth _____ Height _____ Weight _____
Child's Social Security # _____
Home address _____ City, State, Zip code _____
Phone # _____
Reason for today's visit:
_____
_____
_

Mother's Information:
Name _____ Social Security # _____
Date of Birth _____
Work Phone # _____ Cell Phone # _____
Email Address _____

Father's Information:
Name _____ Social Security # _____
Date of Birth _____
Work Phone # _____ Cell Phone # _____
Email Address _____

Insurance Information:
Primary policy holder full name : _____
D.O.B _____
Name of Insurance Carrier: _____
Social Security / ID #: _____
Relationship to patient : _____
Employer: _____

Whom may we thank for referring you to our office? _____
Phone # _____
Pediatrician Name: _____
Phone # _____ Date of last visit _____
Person responsible for child's account
_____

Person to contact in case of emergency _____
Phone # _____

Child's Medical History
Please answer YES or NO. If yes, explain.

Is your child presently under the care of a physician?
_____
Is your child allergic to any food or medicine? What?
_____
Was your child premature? If so, how may weeks?
_____
Is your child currently taking any medication?
_____
Has any member of the family had a negative reaction with general anesthetic?
_____

Has your child had a history of? (Please check all that apply)
( )Scoliosis
( )Stomach Ulcers
( )Heart Trouble/ Murmur
( )Hepatitis or Jaundice
( )Respiratory Problems
( )Pain in jaw muscles
( )Arthritis
( )Painful back teeth
( )Fainting spells/Dizziness
( )Brain Injury
( )Asthma or Hay fever
( )Seizures/Epilepsy
( )Frequent earaches
( )Popping jaw sounds
( )High blood pressure
( )Kidney/Liver problems
( )Diabetes
( )Bleeding Disorders
( )Developmental Delay
( )Other (please describe in full detail)
_____
#If you have any additional concerns or information about your child, please let us know.

Child's Dental History
Is today your child's first dental visit…… YES / NO
Previous Dentist _____
Date of last visit _____
Has your child ever experienced an unfavorable reaction to dental treatment?
_____
How do you think your child will react toward the dentist?
_____
How often does your child brush? _____ Is it supervised & By whom? _____
_____
Is dental floss used? _____ Any trauma or injury to their teeth? _____

Any history of:

( )Thumb or finger-sucking
( )Nursing bottle habits
( )Recent dental pain
( )Mouth breathing
( )Pacifier use
( )Lip sucking
( )Frequent headaches
( )Grinding or clenching

Release And Waiver

I authorize release of any information given regarding dental treatment.

Signature: _____
Date: _____

I have read the above questions and understand them. I will not hold my Pediatric Dentist or any member of his/hers staff responsible for any errors or omission that I have made in the completion of this form. I will notify my Pediatric of any changes in my child medical or dental health.

Signature: _____
Date: _____