Children's Dental Center

Judith Jones, D.D.S. *Kyle T. Sanders, D.D.S.*

1801 S. 5th, Suite 112, McAllen, Texas 78503

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD

Patient's Name _____
Date of Birth_____ Age _____Yrs. _____Mos. Sex_____
Father's Name_____
SS# _____Date of Birth _____
Mailing Address _____
City _____ State _____ Zip Code _____
Contact Phone Number (s) _____, _____, _____
Email _____
Employed By _____ Position _____
Work Number _____
Mother's Name _____
SS# _____Date of Birth_____
Mailing Address _____
City _____ State _____ Zip Code_____
Contact Phone Number(s) _____
Email _____
Employed By _____ Position _____
Work Number _____
At what number(s) can we call you to confirm an appointment? _____ or _____
Whom does patient live with? _____
How are you related to this patient? _____
If you are not the parent, do you have legal guardianship through the court? _____ Yes _____ No

HEALTH HISTORY

Who is your child's pediatrician? _____
Phone # _____
Is your child in good health? _____ Yes _____ No
Is your child up to date with immunization? _____ Yes _____ No
Is your child taking medication at this time? _____ Yes _____ No
If so, what medication? _____
For what reason? _____
Is your child allergic to any medication? _____ Yes _____ No
If so, what medication? _____
Is your child undergoing any type of medical treatment? _____ Yes _____ No
If so, what? _____
Has your child been hospitalized since birth? _____ Yes _____ No
Date _____ For what reason? _____
Has your child had any complications with conscious sedation or general anesthesia? _____ Yes _____ No
If yes, what kind of complications? _____
Has our child had a blood transfusion? _____ Yes _____ No
If yes, Date _____ Place _____

What type of water does your child drink? Tap water Bottled Filtered water

Check only the following that may pertain to your child

_____ Heart Condition or Heart Murmur
_____ Lung Problem
_____ Brain Injury
_____ Liver Problem
_____ Kidney Problem
_____ Epilepsy
_____ Seizures
_____ Convulsions
_____ Diabetes
_____ Cerebral Palsy
_____ Anemia
_____ Hepatitis
_____ Cancer
_____ Radiation or Chemotherapy
_____ Other Medical Problems

_____ Hemophilia
_____ Tuberculosis
_____ Asthma or Bronchitis
_____ Allergies
_____ Retardation
_____ Mental Disorder
_____ Emotional Disorder
_____ Autism
_____ Speech Disorder
_____ Speech Therapy
_____ Hearing Disorder (Deaf)
_____ Vision Disorder (Blind)
_____ Slow Learner
_____ ADD / ADHD
_____ HIV / AIDS

_____ None of the above mentioned

Is this your child's first visit to a dentist? _____ Yes _____ No
If not, date of last dental visit _____

Has your child had a negative experience in a dental office? _____ Yes _____ No

Is your child a finger or thumb sucker? _____ Yes _____ No

How was your child fed? Bottle-fed / Breast-fed Until what age? _____

What is the purpose of this appointment? _____

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment. _____
_____

Who is responsible for this account? _____

Is your child covered under the Texas Medicaid Program? _____ Yes _____ No

Do you have Dental Insurance? _____ Yes _____ No
Name of Insured _____
Name of Carrier _____
Group Number _____ ID # _____

I agree to diagnostic procedures, dental treatment and patient management techniques as found necessary and desirable for the patient above. I authorize release of the information to the patient's medical doctor(s) on record and medical facility.

Date _____ Signature of person legally responsible _____