Patient Name_____ _____ _____
Last First MI

Dental History

What is the reason for today's visit? _____

Is this your child's first visit to a dentist? □ Yes □ No If no, when was the last dental visit? _____

Former dentist, if any? _____

Has your child ever had dental radiographs (x-rays)? □ Yes □ No

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

Has your child ever had problems with dental treatment in the past? _____

Has your child had any orthodontic treatment? _____

Has your child received fluoride supplement? □ Yes □ No If yes, at what age? _____

How many times are your child's teeth brushed per day? When: _____

Has your child sucked his/her thumb, fingers or pacifier? □ Yes □ No Does the habit still exist? □ Yes □ No

At what age did your child stop bottle feeding? _____ Does the child grind his/her teeth? □ Yes □ No

Please describe your child's temperament: □ Friendly □ Talkative □ Quiet/Shy □ Unmanageable □ Nervous

□ Active Independent □ Aggressive □ Stubborn □ Insecure □ Strong-willed □ Whiney

Medical History

1. Is your child taking any prescription and/or over-the-counter medications? □Yes □No
   If yes, please list: _____
2. Is your child allergic to any medication? □Yes □No
   If yes, please list:
3. Is your child allergic to any foods or materials? □Yes □No
   If yes, please list: _____
4. Has your child ever been hospitalized? □Yes □No
   When? _____ Reason? _____
5. Has your child ever been a patient at the emergency room? □Yes □No
   When? _____ Reason? _____
6. Has your child had general anesthesia? □Yes □No
   Any complications with anesthesia? _____

Check (√) if your child has any history or ever been diagnosed with any of the following:

□ Anemia	□ Cerebral Palsy	□ Hormonal disturbances	□ Allergy/Hay fever
□ Chemotherapy	□ Kidney problems	□ Arthritis, Rheumatism	□ Chronic Sinusitis
□ Liver problems	□ Artificial heart valve	□ Cleft lip/palate	□ Measles
□ Artificial joint/limb	□ Diabetes	□ Mental disability	□ Asthma
□ Digestive disturbances	□ Pneumonia	□ Attention Deficit Disorder	□ Eye problems
□ Pregnancy	□ Autism	□ Fainting	□ Rheumatic fever
□ Behavior/Learning Disabilities	□ Growth problem	□ Scarlet fever	□ Birth Defects
□ Hearing loss/aids/implants	□ Handicaps/disabilities	□ Bleeding Disorder	□ Heart murmur
□ Shunt	□ Bone/Joint/Orthopedic problem	□ Heart problem/surgery	□ Tuberculosis
□ Brain injury	□ Hemophilia	□ Venereal disease	□ Brain surgery
□ High/low blood pressure	□ Whooping cough	□ Cancer, type _____	□ HIV/AIDS

□ Other _____

If you have answered **Yes** to any of the above conditions, please provide the **NAME OF YOUR TREATING PHYSICIAN**:

Name of Physician_____Phone#_____

The above information is accurate and complete to the best of my knowledge. I release Dr. Garret Uehara, Dr. Jill Uehara and Dr. Veena Kakarla and their staff from any and all liability that may arise from any and all omissions or failure to disclose any health information, whether intentional or not.

Patient (or Parent if Patient is a minor) Signature_____Date_____

Reviewed by _____Date_____