Samuel B. Burg D.D. S.
Rick J. Kleinsasser D.D.S.
Henry Y. Arakaki D.D. S.

Patients Name _____
Last **First** **Initial** **Date of Birth**

Parents / Guardians Name_____

DENTAL HISTORY - **CIRCLE THE APPROPRIATE ANSWER**

1. Is this your child's first visit to a dentist?..... **YES / NO**
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays or radiographs taken when your child previously visited the dentist? **YES / NO**
4. Does your child eat between meals?..... **YES / NO**
5. Does your child eat sweets, such as candy, soda pop, and chewing gum?..... **YES / NO**
6. Have any cavities been noted in the past?..... **YES / NO**
7. Were any teeth (baby or permanent) removed by extractions?..... **YES / NO**
   Was it suggested that the space be maintained?..... **YES / NO**
   Was an appliance placed?..... **YES / NO**
8. Have there been any injuries to teeth, such as falls, blows, chips, etc?..... **YES / NO**
   Describe _____
9. Has your child had any problems with dental treatment in the past?..... **YES / NO**
10. Has your child ever received a local anesthetic?..... **YES / NO**
11. Has your child ever had occlusal sealants?..... **YES / NO**
12. Do you have any concerns about your child's teeth?..... **YES / NO**

MEDICAL HISTORY

1. **Does your child have a health problem**?..... **YES / NO**
2. Is your child under care of physician?..... **YES / NO**
   If yes, since when and why?_____Phone_____
3. Name of Physician _____
4. **Is your child receiving any medications**?..... **YES / NO**
   What?_____
5. Is your child allergic to penicillin, antibiotics or other drugs?..... **YES / NO**
6. **Is your child allergic to or sensitive to any** metals or **latex**?..... **YES / NO**
7. **Does your child have any other allergies?**..... **YES/ NO**
   What?_____
8. **Has your child had any serious illness**?..... **YES / NO**
   When_____What?_____
9. **Has your child ever had surgery?** ..... **YES / NO**
   When_____ What?_____
10. **Does your child have a heart murmur**?..... **YES / NO**
11. Is any surgery contemplated?..... **YES / NO**
12. Has your child experienced severe or prolongated bleeding?..... **YES / NO**
13. Does your child have AIDS or has he/she tested HIV positive?..... **YES / NO**
14. Has your child tested positive for hepatitis?..... **YES / NO**
15. Is your child subject to nervous disorders?..... **YES / NO**
    { **Fainting?** { **Seizures?** { **Dizziness?** { **Behavioral/Learning problems?**
16. Does your child have frequent headaches?..... **YES / NO**
17. Has your child had history o**f**: **(Circle appropriate responses)**..... **YES / NO**
    diabetes, **heart trouble**, asthma, kidney infection, **rheumatic fever**, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.
    Explain:_____

    _____

RDA_____/_____DR. ***RDA_____/_____DR.***

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE:

PARENT'S / GUARDIAN'S SIGNATURE _____ **DATE**_____

PARENT'S / GUARDIAN'S SIGNATURE_____ **DATE**_____

ANEST.

CHILD DENTAL MEDICAL HISTORY

1430 EAS MAIN STREET κ SUTIE 204 κ SANTA MARIA, CA. 93454 κ (805) 922-3530

MED. ALERT