WELCOME

ABOUT YOUR CHILD

Child's Full Name _____

Age_____ M ☐ F ☐ Date of Birth_____

Reason for Visit _____

_____

_____

DENTAL HISTORY

Child's First Dental Visit? Yes ☐ No☐

Previous Dentists _____

City_____

Date of Last Visit _____ Date of Last X-rays _____

Any injuries to the teeth or jaws? Yes ☐ No ☐

If yes, when_____

Does your child receive:
☐ Fluoride in vitamins ☐ Fluoride tabs/drops
☐ Fluoridated water ☐ None

Has your child experienced any unfavorable reaction from previous medical or dental care? Yes ☐ No ☐

If yes, explain_____

_____

_____

How do you think your child will act towards the dentist?

_____

santa monica dentistry for children

DR. JESSIE SCHWARZ, DMD
DR. ELLEN STONE, DMD
DR. ELANA NORMAN, DDS, MS
DR. ALICE KIM, DMD

2825 Santa Monica Blvd., Suite 301
Santa Monica, CA 90404
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MEDICAL HISTORY

Is your child presently under the care of a physician for any medical reason? Yes ☐ No ☐
If yes, what? _____

Physician/Pediatrician's Name_____

Phone Number_____

Is your child presently under the care of a specialist for any medical reason? Yes ☐ No ☐
If yes, what? _____

Specialist's Name_____

Phone Number_____

	Yes	No
Does your child have a history of health problems? If yes, explain?_____	☐	☐
Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, shunt or other medical reason?	☐	☐
Is your child presently taking any medications? If yes, explain?_____	☐	☐
Has your child had a history of taking frequent medications? If yes, explain?_____	☐	☐
Has your child been hospitalized or had surgery? If yes, explain?_____	☐	☐
Is your child allergic to any drugs? If yes, explain?_____	☐	☐
Is your child allergic to any foods? If yes, explain?_____	☐	☐
Is your child allergic to any medications or dyes? If yes, explain?_____	☐	☐
Is your child allergic to any environmental pollutants? If yes, explain?_____	☐	☐
Is your child allergic to any latex, metals or acrylics? If yes, explain?_____	☐	☐
Has any family member, including your child had a problem with general anesthetic? If yes, explain?_____	☐	☐

Has your child ever been diagnosed as having any of the following conditions? Please check Yes or No.

Y	N		Y	N	
☐	☐	ADHD/ADD	☐	☐	Excessive Bleeding Problem
☐	☐	Aids/HIV	☐	☐	Excessive Gagging
☐	☐	Anemia	☐	☐	Fainting or Dizziness
☐	☐	Arthritis	☐	☐	Fever Blisters
☐	☐	Asthma - What triggers it?	☐	☐	Growth/Developmental Problems
☐	☐	Autism	☐	☐	Heart Surgery
☐	☐	Bladder Conditions	☐	☐	Headaches
☐	☐	Blood Disease	☐	☐	Hearing/Speech Impairments
☐	☐	Blood Transfusions	☐	☐	Heart Murmur/Defects
☐	☐	Birth Defects	☐	☐	Hemophilia
☐	☐	Bone or Joint Problems	☐	☐	Hepatitis/Liver Disease
☐	☐	Brain Injury	☐	☐	High Blood Pressure
☐	☐	Bruising Easily	☐	☐	Kidney Disease
☐	☐	Cancer or Malignancies	☐	☐	Leukemia
☐	☐	Cerebral Palsy	☐	☐	Mental Disability
☐	☐	Chemotherapy/Radiation	☐	☐	Mouth Sores
☐	☐	Child Abuse	☐	☐	Nutritional Deficiency
☐	☐	Chronic Adenoid/Tonsil Infections	☐	☐	Orthopedic Problems
☐	☐	Chronic Ear Infections	☐	☐	Pain in Jaw Joints
☐	☐	Cleft Lip/Palate	☐	☐	Premature Birth
☐	☐	Congenital Heart Lesion	☐	☐	Psychiatric Care
☐	☐	Convulsions/Seizures	☐	☐	Rheumatic Fever
☐	☐	Developmentally Delayed	☐	☐	Scoliosis
☐	☐	Diabetes	☐	☐	Sickle Cell Anemia
☐	☐	Drug Addiction	☐	☐	Syndrome_____
☐	☐	Ear Stuffiness, Itching or Noises	☐	☐	Tuberculosis
☐	☐	Emotional Disturbance	☐	☐	Other _____
☐	☐	Epilepsy	☐	☐	Do you wish to talk to the doctor privately about a special concern?
☐	☐	Eye Problems			

PLEASE COMPLETE BOTH SIDES OF THIS FORM. THANK YOU

RESPONSIBLE PARTY

Father/Guardian Full Name _____

Address _____

City _____ State _____ ZIP _____

SS# _____ Birth Date _____

Home Phone _____ Business Phone _____

Cell Phone _____ Email Address _____

Employer _____ Occupation _____

Mother/Guardian Full Name _____

Address _____

City _____ State _____ ZIP _____

SS# _____ Birth Date _____

Home Phone _____ Business Phone _____

Cell Phone _____ Email Address _____

Employer _____ Occupation _____

Is patient living with both parents? Yes ☐ No ☐

If no, with whom does the child reside? _____

SIBLINGS

Name _____ Birth Date _____

Name _____ Birth Date _____

Name _____ Birth Date _____

NEAREST RELATIVE/FRIEND

Name _____

Address _____

Phone _____ Relationship _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance _____

Group # _____

Policy Holder Name _____

Secondary _____

Group # _____

Policy Holder Name _____

CONSENT FOR TREATMENT

I am the (parent/guardian) of _____ (name of child) who is a minor child, and I authorize examination and treatment as necessary by or under the supervision of Dr. Jessie Schwarz, DMD and/or Dr. Ellen Stone, DMD. This includes exposure of radiographs as necessary, use of local anesthesia, inhalation and oral medication, responsible restraint as needed and use of appropriate medicaments and materials for such treatment. If I have any objections to certain aspects of treatment, I have stated so in the space provided below. I will assume responsibility for fees associated with those procedures for my child.

_____

Parent/Guardian Signature

Date _____

PLEASE NOTE: Payment is expected for service rendered at the time of treatment. If the family is not living together the parent bringing the child is responsible for the child's account.

SCHOOL INFORMATION

Name of Preschool or Elementary School your child attends or will attend:

_____

Referred ToThis Office By:

Full Name _____

Phone Number _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM. THANK YOU