

Child Information

Patient Name: (First) _____ (M.I.) _____ (Last) _____

Sex: M F DOB: ____/____/____ Name of School: _____

Home Address: _____ City: _____

Home Phone Number: (____) ____ - _____ Best Contact Number: (____) ____ - _____

Parent Information

Father's Name: (First) _____ (M.I.) _____ (Last) _____ Date of Birth: ____/____/____

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State ____ Zip code _____

Work Phone Number: (____) ____ - _____ Ext. _____

Mother's Name: (First) _____ (M.I.) _____ (Last) _____ Date of Birth: ____/____/____

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State ____ Zip code _____

Work Phone Number: (____) ____ - _____ Ext. _____

Emergency Contact: _____ Phone # (____) ____ - _____

Person responsible for account: _____

Whom may we thank for referring you? _____

Dental Health

Reason for your visit: _____ Last teeth cleaning: _____

What is your *primary* concern that you wish us to address first? _____

Have you ever had any problems with previous dental treatment? Yes No

If yes, please explain here: _____

Are your teeth sensitive? Yes No

Do your gums feel tender or swollen? Yes No

How often do you brush your teeth? _____ How often do you floss? _____

Do you have pain with any of the following? Chewing hot liquids cold liquids sweets none

Are you aware of grinding or clenching your teeth? Yes No

Jeffrey A. Diamond, DDS
Legacy Dental Care
158 Second Street, Los Altos, CA 94022

Medical History

General health: Excellent Good Fair Poor

Name of physician: _____ Telephone Number: _____

Physician's address: _____

Have you ever been hospitalized? Yes No If yes, please list reason: _____

Are you allergic to any medications? Yes No If yes, please list here: _____

Are you taking any medications? Yes No If yes, please list current medications below:

Have you ever had any of the following?

| | | | | | |
|------------------------------------|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| Allergy (Hay Fever) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Hepatitis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Sinus or Ear Trouble | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Blood Disorder (Anemia, Leukemia) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Respiratory Condition | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Excessive Bleeding | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Severe or Frequent Headaches | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Epilepsy | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Abnormal High/Low Blood Pressure | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Kidney Disorder or Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Thyroid Condition (Hyper/Hypo) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Skin Problem or Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Parkinson's Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Nervous Disorder, Psychiatric Care | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Eye Disease (Glaucoma, Cataract) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Ulcer | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Retinal Eye Surgery | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cancer, Tumors, Malignancies | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Heart Disease/Condition | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| X-ray, Radium or Cobalt Treatment | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Rheumatic Fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Herpes, Cold sores, Fever blisters | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Scarlet Fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| AIDS or HIV exposure | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Heart Murmur | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Stroke | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Transplants | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Arthritis | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Artificial Implants (Pacemakers, etc.) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If you have answered "yes" to any of the above, please explain here:

What are your hobbies? Special interests?

Signature _____

Date _____

If patient is less than 18 years old, parent or legal guardian must sign above.