
Iman Abdeshahian, DMD

# Pediatric Dental/Medical History Form

**Dental Wellness Center**
5406 E. Village Road
Long Beach , CA , 90808

(562) 421-3747
www.LongBeachHolisticDentist.com
leanne@LBDWC.com

## Tell Us About Your Child

Child's Name: _____ _____ _____ Nickname: _____
Last Name First Name MI

Gender: ◯ Male ◯ Female Birth Date: _____ Age: _____

School: _____ Grade: _____

Child's Home #: _____ SS#: _____

Child's Home Address: _____

City: _____ State: _____ Zip Code: _____

## Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ◯ Yes ◯ No Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____ Last Visit Date: _____

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Separated

### Mother of Child

Name: _____
Birthdate: _____ Cell Ph: _____
Hm Ph: _____ Wk Ph: _____
Employer: _____
Email: _____
SS#: _____ DL#: _____

### Father of Child

Name: _____
Birthdate: _____ Cell Ph: _____
Hm Ph: _____ Wk Ph: _____
Employer: _____
Email: _____
SS#: _____ DL#: _____

## Person responsible for account

### Billing:

Name: _____ _____ _____ Relation: _____
Last Name First Name MI

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Home Ph. _____ Employer: _____ Work #: _____

### Appointments:

Name: _____ _____ _____ Hm # _____ Wk #: _____
Last Name First Name MI

### Primary Dental Insurance

Insurance Co. Name: _____
Group # (Plan,Local, or Policy #): _____
Address: _____
Phone #: _____
Policy Owner Name: _____
Relationship to Patient: _____
Birthdate: _____ SS#: _____
Employer: _____

### Secondary Dental Insurance

Insurance Co. Name: _____
Group # (Plan,Local, or Policy #): _____
Address: _____
Phone #: _____
Policy Owner Name: _____
Relationship to Patient: _____
Birthdate: _____ SS#: _____
Employer: _____

## What is the primary reason for the child's appointment?

**Reason for first visit:**

Child's Interests, Hobbies: _____

| | |
|---|---|
| Has the child ever had a serious/difficult problem associated with previous dental treatment? | ◯ Yes ◯ No |
| Is the child's water fluoridated? | ◯ Yes ◯ No |
| Is the child taking fluoridated supplements? | ◯ Yes ◯ No |
| Has the child ever had any pain/tenderness in his/her jawjoint (TMJ/TMD)? | ◯ Yes ◯ No |
| Does the child have headaches, neck pain or balance problems? | ◯ Yes ◯ No |
| Does the child brush his/her teeth daily? | ◯ Yes ◯ No |
| Does the child floss (or someone) his/her teeth daily? | ◯ Yes ◯ No |

Child's Physician: _____ Phone: _____ Last Visit: _____

Is the child currently under the care of a physician? ◯ Yes ◯ No

Please describe the child's current physical health: ◯ Good ◯ Fair ◯ Poor

Please list all drugs that the child is currently taking: _____

Please list all drugs/materials that the child is allergic to: _____

## Has the child ever had any of the following medical problems?

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Abnormal Bleeding | ◯ | ◯ | Congenital Heart Defect | ◯ | ◯ | Hemophilia | ◯ | ◯ |
| Drug Allergies | ◯ | ◯ | Convulsions/Epilepsy | ◯ | ◯ | Hepatitis | ◯ | ◯ |
| Any Hospital Stays | ◯ | ◯ | Diabetes | ◯ | ◯ | HIV+/AIDS | ◯ | ◯ |
| Any Operations | ◯ | ◯ | Handicaps/Disabilities | ◯ | ◯ | Kidney/Liver | ◯ | ◯ |
| Asthma | ◯ | ◯ | Hearing Impairment | ◯ | ◯ | Rheumatic/Scarlet Fever | ◯ | ◯ |
| Cancer | ◯ | ◯ | Heart Murmur | ◯ | ◯ | Tuberculosis | ◯ | ◯ |

Please discuss any serious medical problems that the child has had: _____

## Does the child have any of the following habits?

| | | | | | |
|---|---|---|---|---|---|
| Lip Sucking/Biting | ◯ Yes | ◯ No | Nail Biting | ◯ Yes | ◯ No |
| Nursing Bottle Habits | ◯ Yes | ◯ No | Thumb/Finger Sucking | ◯ Yes | ◯ No |

**Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. **I authorize the dental staff to perform the necessary dental services my child may need.**

Signature of Parent or Guardian: _____ Date: _____

**The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.**