Harold Perlaza, D.D.S

PATIENT HISTORY & INFORMATION (for children up to age 18)

MEDICAL HISTORY

Child's Name. _____ (Last / First / Middle Initial) Birthdate: _____ Sex _____

Physician's Name: _____ City/State: _____ Phone: _____

Last consultation/visit with a physician? _____ Reason: _____

Last physical examination? _____ Results: _____

Been a patient in a hospital in the past 5 years: ☐ Yes ☐ No Reason: _____

Had any serious illness or operations? ☐ Yes ☐ No Type: _____

Ever had blood transfused? ☐ Yes ☐ No When: _____

Have now, or ever had, any of the following (Please check and describe fully under remarks):

	Yes	No		Yes	No		Yes	No
1 Heart Disease	☐	☐	14. Persistent Swollen Glands	☐	☐	27. Jaundice	☐	☐
2 High Blood Pressure	☐	☐	15. Psychiatric Treatment	☐	☐	28. Hepatitis, A or B	☐	☐
3. Blood Disorder — Anemia	☐	☐	16. Arthritis	☐	☐	29. Chronic Headaches	☐	☐
4 Rheumatic Fever	☐	☐	17. Night Sweats	☐	☐	30. Ringing in the Ears	☐	☐
5 Heart Murmur	☐	☐	18. Persistent Cough	☐	☐	31. Allergies		
6 Artificial Joints or Devices	☐	☐	19. Tumor History	☐	☐	a. Penicillin	☐	☐
7 Heart Valve Damage or Surgery	☐	☐	20. Chemotherapy	☐	☐	b Other Antibiotics	☐	☐
8 Chest Pain	☐	☐	21. Radiation Treatment	☐	☐	c. Codeine, Aspirin.	☐	☐
9 Thyroid Disease, Hyperthyroidism	☐	☐	22. Immune System Disorders	☐	☐	d Local Anesthetic, Novocain	☐	☐
10 Diabetes	☐	☐	23. AIDS, ARC or HIV Infection	☐	☐	e. Latex	☐	☐
11 Stroke	☐	☐	24. Sinus Trouble	☐	☐	f. Others	☐	☐
12 Epilepsy or Seizures	☐	☐	25. Ulcers	☐	☐	32. Asthma	☐	☐
13 Fainting	☐	☐	26. Liver or Kidney Disease	☐	☐	33. Tuberculosis, Emphysema	☐	☐

Had excessive bleeding requiring treatment? ☐ Yes ☐ No

Taking any medicines, drugs or pills? ☐ Yes ☐ No If yes, what? _____

Have any disease, condition or problem not listed above? _____

_____

_____

_____

_____

DENTAL HISTORY

Does or has your child:

1. Experienced any unfavorable reactions to previous dental treatment? ☐ Yes ☐ No
2. Have gums that bleed when brushed? ☐ Yes ☐ No
3. Chew properly and without pain? ☐ Yes ☐ No
4. Brush teeth daily? ☐ Yes ☐ No
5. Is Fluoride being taken daily? ☐ Yes ☐ No
6. Had or need orthodontic treatment? ☐ Yes ☐ No
7. Have stains or discoloration on teeth? ☐ Yes ☐ No
8. Require premedication prior to dental treatment? ☐ Yes ☐ No
9. Name of former dentist: _____ Date of last exam: _____
10. Please note any special dental concerns that bring you to our office: _____

_____

_____

_____

Parent (or Guardian) Signature _____ Date _____

Doctor's Signature _____ Date _____

PATIENT REGISTRATION (for children up to age 18)

PLEASE PRINT

Child's Name _____ Birthdate: _____ Sex: _____
Last First Middle Initial

Parent or Guardian: _____ Home Phone: _____
Last First

Parent's Social Security No.: _____ Driver's License No.: _____ Bus. Phone _____

Address (Home) _____
Street City State/Zip

Address (Bus) _____
Street City State/Zip

Is child covered by an insurance plan? Yes ☐ No ☐

INSURANCE COMPANY: _____ Group No.: _____ Certificate No.: _____

Employer's Name: _____ Employee Name: _____

Insurance Eligibility Date: _____ Secondary Coverage: _____

Who is financially responsible for this patient? _____

Who can we thank for referring you to our office? _____

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in health or medications, I will inform the doctor at the next appointment. I grant permission for my child's physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, and other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.

_____ _____
Parent or Guardian Date

HEALTH UPDATES

Changes	Parent's or Guardian's Signature	Date