Grace Kwon, DDS
Menlo Pediatric Dentistry

Patient Information Form

Patient(s) Last name_____

Address_____

City_____ Zip code_____

Child 2 First name_____

Nickname_____

Birthdate_____

Child 1 First name_____

Nickname_____

Birthdate_____

Child 3 First name_____

Nickname _____

Birthdate _____

Responsible Party

With whom does patient live?_____ Person responsible for account?_____

Who brought patient today?_____ Does patient have dental insurance?_____

Parent or Guardian Information

_____Mother _____ Step Mother_____ Guardian

Name_____

Address_____

City_____ Zip code _____

Mobile # _____

Home # _____

Work # _____

E-mail _____

_____Father _____Step Father _____Guardian

Name _____

Address _____

City_____ Zip Code_____

Mobile # _____

Home # _____

Work # _____

E-mail _____

Primary Insurance

Name of insured parent_____

Birthdate _____

ID # or SSN _____

Employer _____

Carrier _____

Group # _____

Secondary Insurance

Name of insured parent_____

Birthdate _____

ID # or SSN _____

Employer _____

Carrier _____

Group # _____

Whom may we thank for referring you to our office? _____

*I have reviewed the information on this form and it is accurate to the best of my knowledge.

*I also acknowledge that the Dental Materials Fact Sheet has been made available to me.

_____ _____

Signature of Parent/Guardian Date

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Health History

Name _____ Birthdate_____

Your child's health, as well as any medications which your child takes, can have an interrelationship with the dental care your child receives. Please answer each question completely.

How often does your child brush? _____
How often does your child floss? _____

Has your child ever had the following?
(Please check any that apply below)

Does your child:	Yes	No
Take fluoride supplements?	___	___
Use a pacifier?	___	___
Suck thumb or finger?	___	___
Suck or bite lip?	___	___
Bite or chew nails?	____	____
Grind teeth?	____	____
Clench jaws?	____	____
Gag easily?	_____	___
Was your child breastfed?	____	____
Age Discontinued? _____		
Was your child bottle-fed?	____	____
Age Discontinued? _____		

____Autism ____Anemia
____Asthma ____Mental Disorder
____Developmental Delay
____Brain injury ____Speech Disorder
____ Cancer ____Cerebral Palsy
____Tuberculosis____ Diabetes
____HIV/AIDS ____ Vision Disorder
_____Bleeding Disorder
_____Congenital Heart Defect

Other_____
_____

Current medications taken_____

Allergies or adverse reaction to medication (e.g. Penicillin, Sulfas)_____

Allergies to any substances (e.g. latex) _____

Previous hospitalization, surgeries or serious illnesses_____

Has your child had difficulty with previous dental visits? _____

Date of last dental visit? _____ Child's Pediatrician_____

Previous dentist _____ Pediatrician's Phone # _____

Is there anything specific you'd like to discuss today? _____

_____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can out my Child's health at risk and that it is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners as necessary.

X _____ _____
Signature of Parent/Guardian Date