MELBA Z. MAYES, D.D.S., M.S.
PEDIATRIC DENTISTRY
2140 GRAND AVENUE, SUITE 200 • CHINO HILLS, CALIFORNIA 91709
(909) 548-4044 • (909) 548-0848 FACSIMILE

Dr. Mayes and her staff are pleased to welcome you and your child to our practice. Please take a few minutes to fill out these forms as completely as you can. If you have questions, we will be glad to help you. We look forward to working with you in maintaining your child's dental health!

TELLS US ABOUT YOUR CHILD

Child's Name:		Nickname:
Sex: Female / Male	Child's age:	DOB:
Child's Home Address:		School:
Phone:		Grade:
Child's Hobbies/Pets:		
Name & Age of Child's Siblings:		

DENTAL HISTORY

Is this your child's first visit to the dentist?	Yes	No
If no, give date of last dental visit:		
Were x-rays taken?	Yes	No
If yes, give date of last dental x-rays:		
Was your child cooperative at the last dental visit?	Yes	No
Has your child ever had an unfavorable dental experience?	Yes	No
Who may we thank for referring you?		
What is the name of your family dentist?		

Please indicate if your child has had any of the following:

Bad breath	Yes	No	Bleeding gums	Yes	No
Grinding teeth	Yes	No	Broken teeth	Yes	No
Tooth abscess/gum boil	Yes	No	Clenching teeth	Yes	No
Broken fillings	Yes	No	Gums swollen or tender	Yes	No
Mouth breathing	Yes	No	Sensitivity to chewing	Yes	No
Cold sores/ fever blisters	Yes	No	Finger or thumb sucking	Yes	No
Chew on one side	Yes	No	Blisters on lips or mouth	Yes	No
Fingernail biting	Yes	No	Loose teeth	Yes	No
Swelling or lumps in the mouth	Yes	No	Lip biting or sucking	Yes	No
Stained teeth	Yes	No	Orthodontic treatment	Yes	No
Tongue habit	Yes	No	Injury to teeth	Yes	No
Difficulty opening mouth	Yes	No	Chewing on objects	Yes	No
Toothaches	Yes	No	Clicking or popping of jaw	Yes	No
Pacifier habit	Yes	No	Sensitivity to cold	Yes	No
Jaw pain or tiredness	Yes	No	Burning sensation	Yes	No
Sensitivity to hot	Yes	No	Jaw sometimes lock	Yes	No
Dry mouth	Yes	No	Sensitivity to sweets	Yes	No
Injury to head, jaw, or chin	Yes	No	Does your child have, or did he or she ever have, a sucking habit beyond one year of age?	Yes	No

Reason for today's visit: (Circle all that apply)
Abscess/Infection Bleeding gums Dental Injury Regular Exam Toothache
Other:_____

Was your child nursed beyond one year of age? Nursing Bottle Both Until what age?_____

By what sources does your child receive fluoride? (Circle all that apply)
Gel Liquid Rinse Pills Toothpaste Vitamins

Does your child brush daily?	Yes	No
How often?		
Does your child use dental floss?	Yes	No
How often?:		
Does an adult help your child daily with brushing the teeth?	Yes	No
Does an adult check nightly for thoroughness after brushing/flossing?	Yes	No

MEDICAL HISTORY

Child's Physician:				
Phone:				
Address:				
City:	State:	Zip:		
Does your child have any health problems?			Yes	No
Has your child seen a physician in the past 12 months?			Yes	No
Has your child been hospitalized or been in the emergency room in the past 12 months?			Yes	No
Is your child under the care of a physician at this time?			Yes	No
Date and reason for last medical examination:				
Is your child taking any medications?			Yes	No
If yes, please list names of medications and dosages				
Were difficulties encountered during pregnancy or delivery of child?			Yes	No
If yes, please explain:				

Does your child have any history of allergic reactions: (Circle all that apply)
Environment (Dust, Pollen) Food Latex Local Anesthetic Medications (Amoxicillin, Penicillin, Sulfa)
Other:_____

Blood and Immune System □Yes □No Bleeding tendency □Yes □No clotting disorder □Yes □No Anemia □Yes □No Sickle cell anemia or trait □Yes □No Blood transfusion □Yes □No Bruising problem □Yes □No Positive blood test for HIV □Yes □No Skin blotches or rashes **Heart and Blood Vessels** □Yes □No Congenital Heart Disease □Yes □No Rheumatic Fever □Yes □No Heart Murmur □Yes □No Heart transplant/Valve problem □Yes □No Pacemaker □Yes □No Irregular heart beat □Yes □No High Blood Pressure **Respiratory** □Yes □No Breathing or lung problems □Yes □No Sinus problems □Yes □No Asthma □Yes □No Hay Fever □Yes □No Frequent nosebleeds	**Bones and Muscles** □Yes □No **J**oint pain/arthritis/rheumatism □Yes □No Prosthetic or artificial joints □Yes □No Muscular dystrophy □Yes □No Physical disabilities **Endocrine/GI System/GU System** □Yes □No Diabetes □Yes □No Family history of diabetes □Yes □No Thyroid/goiter or adrenal gland problem □Yes □No Dry Mouth □Yes □No Hepatitis □Yes □No Unexplained nausea or vomiting □Yes □No Intestinal or stomach problems □Yes □No Unexplained weight loss or gain □Yes □No Kidney problem □Yes □No Liver problem □Yes □No Frequency of urination/bladder disease **Eyes and Ears** □Yes □No Eye problem □Yes □No Deafness/Hearing loss **Oncology** □Yes □No Tumors/Cancer/Leukemia □Yes □No Chemotherapy/Radiation therapy	**Nervous System** □Yes □No Attention Deficit Disorder □Yes □No Autism □Yes □No Brain injury □Yes □No Cerebral palsy □Yes □No Convulsion/seizures/epilepsy □Yes □No Dizziness/problems with balance □Yes □No Fainting spells/loss of consciousness □Yes □No Mental problems □Yes □No Neurological problems □Yes □No Paralysis/Polio □Yes □No Psychiatric disorder **Genetic/Developmental** □Yes □No Birth defect □Yes □No Cleft lip □Yes □No Cleft palate □Yes □No Down's Syndrome □Yes □No Other Genetic disorder □Yes □No Other Syndrome □Yes □No Any other medical problem not mentioned **Other** □Yes □No Car/motion sickness □Yes □No Concentration problems □Yes □No Cooperating problems □Yes □No Fear of strangers □Yes □No Speech problems □Yes □No Understanding problems

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____
_____ Please print the name or Minor/child) and there are no court orders now in effect that prohibit me from signing this consent. I understand that the personal/medical/dental information that I have given is complete and correct to the best of my knowledge. I understand 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 also authorize the dental staff to perform the necessary dental services my child may need.

Date:_____ _____
Signature of Parent, Guardian or Personal Representative

Date:_____ _____
Melba Z. Mayes, D.D.S., M.S.

Due to potential acquisition of other patients protected health information (PHI), recording any part of or your visit to our office is strictly prohibited.