BAY AREA PEDIATRIC DENTAL WELLNESS GROUP

JONATHON EVERETT LEE, DDS, INC. ~ BRIAN D. LEE, DDS, MSD, INC. ~ CHRISTIAN P. YEE, DDS
Diplomates of the American Board of Pediatric Dentistry
Specializing in Dentistry for Infants, Children & Teenagers and Orthodontics

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Welcome

TELL US ABOUT YOUR CHILD

Child's Name: _____ *Nickname:* _____
First *Middle* *Last*

Sex: Male ☐ *Female* ☐ *Birth Date:* _____ *Age:* _____ *Guardianship: Parent* ☐ *Adopted* ☐ *Legal* ☐

Home Address: _____ *City:* _____ *ZIP Code:* _____

Names and ages of brothers and sisters: _____

Has any member of your family been a patient of Dr. Lee's in the past? Yes ☐ *No* ☐ *Name(s):* _____

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

Address: _____ *Telephone:* _____

Please list your child's interests and hobbies:

a) _____ *d)* _____
b) _____ *e)* _____
c) _____ *f)* _____

What prompted you to phone our office?

What do you hope to accomplish from your meeting with us?

What things, from previous dental experiences, would you like to find in our office?

What experiences would you hope to avoid or eliminate?

Are there any problems, issues or challenges you would like us to help you with? Please explain.

What should we know about you in order to work most effectively with you and your family?

GENERAL INFORMATION

Person responsible for this account: Father ☐ Mother ☐ Other: _____

Do mother, father and child live together? Yes ☐ No ☐ If no, please explain: _____

Father's Full Name: _____ Birth Date: _____ Marital Status: _____

Home Address: _____ City: _____ ZIP Code: _____

Hm Tel: _____ Cell: _____ E-Mail: _____

Employer: _____ Occupation: _____ How long with present firm? _____

Wk Address: _____ Wk Tel: _____

California Driver's License or ID #: _____

Mother's Full Name: _____ Birth Date: _____ Marital Status: _____

Home Address: _____ City: _____ ZIP Code: _____

Hm Tel: _____ Cell: _____ E-Mail: _____

Employer: _____ Occupation: _____ How long with present firm? _____

Wk Address: _____ Wk Tel: _____

California Driver's License or ID #: _____

Person to notify in case of emergency: Name: _____

Home Address: _____ Hm Tel: _____

INSURANCE INFORMATION

Is child covered by any dental insurance plan? Yes ☐ No ☐ If yes, please answer the following:

Name of Primary Dental Plan: _____ Group Number: _____

1. *Name of Employee covered under Primary Plan: _____*
2. *His/Her Social Security Number: _____*
3. *Name of Union and Local Number: _____*
4. *Has the child had previous dental care under this plan? Yes ☐ No ☐*

Name of Secondary Dental Plan: _____ Group Number: _____

1. *Name of Employee covered under Secondary Plan: _____*
2. *His/Her Social Security Number: _____*
3. *Name of Union and Local Number: _____*
4. *Has the child had previous dental care under this plan? Yes ☐ No ☐*

Patient's Name: _____

HEALTH HISTORY

This information can be of great value in aiding us to a better understanding of your child in providing dental health care.

Medical

Name of family physician or pediatrician: _____ *Date of Last Exam:* _____

Address: _____ *Telephone:* _____

Is your child in good health? ..... *Yes* ☐ *No* ☐
Does your child have regular medical check-ups? ..... *Yes* ☐ *No* ☐
Are your child's immunizations up to date? ..... *Yes* ☐ *No* ☐
Is your child allergic to rubber latex or drug medications such as antibiotics or local anesthetics? *Yes* ☐ *No* ☐
Is your child allergic to anything else? ..... *Yes* ☐ *No* ☐

If YES Please List & Describe: _____

Is your child presently taking any medications? ..... *Yes* ☐ *No* ☐
If YES, what type of medication(s) dose(s) and for what condition(s)?

_____

Is your child taking, has taken or is scheduled to begin taking: fenfluramine (Pondimin), dexphenfluramine (Redux), fenfluramine-phentermine combination (Fen-phen), alendronate (Fosamax), risedronate (Actonel) or IV bisphosphonates (Aredia or Zometa)? *Yes* ☐ *No* ☐

If YES, what type of medication(s) dose(s) and for what condition(s)?

_____

Has your child ever been hospitalized or sustained significant injuries? ..... *Yes* ☐ *No* ☐

If YES, why? _____

Does your child have Autism, Pervasive Developmental Disorder or Autistic Spectrum Disorder? ..... *Yes* ☐ *No* ☐
Do you consider your child to be high strung or nervous? ..... *Yes* ☐ *No* ☐

Has your child had any history or difficulty with any of the following:

Premature Birth	*Yes* ☐	*No* ☐	*Behavior or Learning Problems*	*Yes* ☐	*No* ☐
Birth Defects	*Yes* ☐	*No* ☐	*Adverse Drug Reaction*	*Yes* ☐	*No* ☐
Genetic Syndrome	*Yes* ☐	*No* ☐	*Allergies*	*Yes* ☐	*No* ☐
Bone Disorders	*Yes* ☐	*No* ☐	*Heart Problems or Murmur*	*Yes* ☐	*No* ☐
Cancer	*Yes* ☐	*No* ☐	*Mitral Valve Prolapse*	*Yes* ☐	*No* ☐
Difficult First Year of Life	*Yes* ☐	*No* ☐	*Rheumatic or Scarlet Fever*	*Yes* ☐	*No* ☐
Frequent Infections	*Yes* ☐	*No* ☐	*Bleeding Problems or Bruising*	*Yes* ☐	*No* ☐
Ear Infections	*Yes* ☐	*No* ☐	*Anemia*	*Yes* ☐	*No* ☐
Immune Disorders	*Yes* ☐	*No* ☐	*Blood Transfusions*	*Yes* ☐	*No* ☐
High Fever	*Yes* ☐	*No* ☐	*Breathing or Lung Problems*	*Yes* ☐	*No* ☐
Convulsions/Seizures	*Yes* ☐	*No* ☐	*Asthma*	*Yes* ☐	*No* ☐
Epilepsy	*Yes* ☐	*No* ☐	*Tuberculosis*	*Yes* ☐	*No* ☐
Brain Injury	*Yes* ☐	*No* ☐	*Diabetes or Endocrine Problems*	*Yes* ☐	*No* ☐
Recurrent Headaches	*Yes* ☐	*No* ☐	*Eye Problems*	*Yes* ☐	*No* ☐
Fainting , Dizziness or Motion Sickness	*Yes* ☐	*No* ☐	*Liver*	*Yes* ☐	*No* ☐
Cerebral Palsy	*Yes* ☐	*No* ☐	*Hepatitis*	*Yes* ☐	*No* ☐
Mental Retardation	*Yes* ☐	*No* ☐	*Gagging*	*Yes* ☐	*No* ☐
Delayed Development	*Yes* ☐	*No* ☐	*Gastric, Reflux or Digestive Problems*	*Yes* ☐	*No* ☐
Speech or Hearing Problems	*Yes* ☐	*No* ☐	*Kidney or Bladder Problems*	*Yes* ☐	*No* ☐
Attention Deficit Disorder	*Yes* ☐	*No* ☐	*Other*	*Yes* ☐	*No* ☐

If YES, please explain: _____

_____

Dental

Give the date of last dental exam or care and location: _____

Name of former dentist: _____

Address: _____ *Telephone:* _____

Has your child taken Dental X-Rays? ..... *Yes* ☐ *No* ☐
Has your child had any unfavorable reaction from any previous dental care? ..... *Yes* ☐ *No* ☐

If yes, please explain: _____

_____

Has mother or father had a lot of dental decay? ..... *Yes* ☐ *No* ☐
Is your child still nursing on the Bottle or Breast? ..... *Yes* ☐ *No* ☐

What is your child's Primary Water Source (i.e., tap, filtered, bottled, etc)? _____

Has your child had any history of:

Fluoride Treatments	*Yes* ☐	*No* ☐	*Pain*	*Yes* ☐	*No* ☐
Thumb Sucking	*Yes* ☐	*No* ☐	*Broken Teeth*	*Yes* ☐	*No* ☐
Finger Sucking	*Yes* ☐	*No* ☐	*Extracted Teeth*	*Yes* ☐	*No* ☐
Lip Biting	*Yes* ☐	*No* ☐	*Gum Infections*	*Yes* ☐	*No* ☐
Nail Biting	*Yes* ☐	*No* ☐	*Missing Permanent Teeth*	*Yes* ☐	*No* ☐
Pacifier	*Yes* ☐	*No* ☐	*Extra Permanent Teeth*	*Yes* ☐	*No* ☐
Clenching or Grinding	*Yes* ☐	*No* ☐	*Injuries to Face, Mouth or Teeth*	*Yes* ☐	*No* ☐
Mouth Breathing	*Yes* ☐	*No* ☐	*Orthodontics*	*Yes* ☐	*No* ☐
Cavities	*Yes* ☐	*No* ☐	*Jaw Pain, TMJ or TMD History*	*Yes* ☐	*No* ☐
Toothaches	*Yes* ☐	*No* ☐	*Other*	*Yes* ☐	*No* ☐

To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr(s).Lee, Lee, Yee or one of their associate or staff members of any change in the patient's health and/or medication.

Signature _____ *Date* _____
(Parent or Guardian)

PERMISSION FOR DENTAL TREATMENT

I hereby give permission to Jonathon Everett Lee, D.D.S., Brian D. Lee, D.D.S., M.S.D., Christian P. Yee, D.D.S., and their respective associates and staff to render all necessary dental services and to use such methods and agents as they see fit for the child named on this form. I understand that no treatment will be started until recommended treatment, time involved, and financial investment has been discussed with me or my representative by either Drs. Lee, Lee, or Yee or one of their associates or staff members, at which time I may void this permission if I so choose. Furthermore, I will be responsible for any bills incurred on this child for dental treatment. I understand that this practice renders services in the best interest of the health of the patient, and makes no assumption that these services will be paid by the insurance company.

Signature _____ *Date* _____
(Parent or Guardian)

FOR OFFICE USE ONLY: *DATE:* _____ *CHECK IN:* _____ *DAU:* _____ *DDS:* _____

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