Simi Childrens Dental Group

Dentistry for Children & Teens
Orthodontics for All Ages

Health History Form

** indicates a response is required*

Date _____

Patient Information

Child's name _____ Date of birth _____ ○M ○F
LAST FIRST NICKNAME

Address _____
STREET CITY STATE ZIP

Phone _____ School _____ Grade _____

Names and ages of other children in family _____

* Referred by _____

Parent Information

Father's Name _____ Date of Birth _____
LAST FIRST MI

Address (if different) _____ Home Ph _____
STREET CITY STATE ZIP

Cell Phone _____ Email _____

* SSN _____ * Driver's License # _____

Employer _____ Work Ph _____

* Marital Staus: ○ Single ○ Married ○ Divorced ○ If married, Spouse's name: _____

Mother's Name _____ Date of Birth _____
LAST FIRST MI

Address (if different) _____ Home Ph _____
STREET CITY STATE ZIP

Cell Phone _____ Email _____

* SSN _____ * Driver's License # _____

Employer _____ Work Ph _____

* Marital Staus: ○ Single ○ Married ○ Divorced ○ If married, Spouse's name: _____

Dental Insurance Information

Insured's Name _____ Date of Birth _____
LAST FIRST MI

* Employer _____ Insurance Company _____

Group No. _____ SSN or ID No. _____

* Does your child have dual coverage? Yes ☐ No ☐

Insured's Name _____ Date of Birth _____
LAST FIRST MI

Employer _____ Insurance Company _____

Group No. _____ SSN or ID No. _____

Emergency Contact: Name _____ Phone: _____

1755 Erringer Road, Suite 20 • Simi Valley, CA 93065 • phone: 805.522.2164 • fax: 805.522.9849

Dental History

Is this your child's first dental visit? ○ Yes ○ No
Previous Dentist _____
Date of Last Visit _____

Have there been any injuries to your child's face/mouth/teeth? ○ Yes ○ No

Does your child have any speech problems? ○ Yes ○ No

How often does your child brush? _____

Is tooth brushing supervised? ○ Yes ○ No
By Whom? _____ When? _____

Does your child clench or grind their teeth? ○ Yes ○ No

Does your child have any habits such as Thumb or finger sucking, pacifier use, nail biting, lip/cheek biting? _____ ○ Yes ○ No

Is your child currently nursing or using a bottle? ○ Yes ○ No
Age discontinued? _____

Is dental floss used? ○ Yes ○ No

Does your child receive Fluoride? ○ Yes ○ No
From what source _____

Has your child experienced any unfavorable reaction from previous dental or medical care? _____

How do you think your child will act towards the dentist? _____

Do you have any specific dental concerns that you want addressed? _____

Medical History

Child's Height _____ Weight _____

Is your child in good health? ○ Yes ○ No

Does your child have any history of major illness? ○ Yes ○ No
If so, what? _____

Check any of the following for which your child has been treated:

- ○ Diabetes
- ○ Pneumonia
- ○ Heart trouble
- ○ ADD/ADHD
- ○ Bone disorder
- ○ Herpes
- ○ Anemia
- ○ Epilepsy
- ○ Asthma
- ○ Autism/Sensory Integration Disorder
- ○ Kidney involvement
- ○ Tuberculosis
- ○ AIDS
- ○ Prolonged Bleeding
- ○ Fainting/dizziness
- ○ Nervous disorders
- ○ Liver involvement
- ○ Endocrine problems
- ○ Other: _____

Have the tonsils/adenoids been removed? ○ Yes ○ No
If so, at what age? _____

List any drugs/medications your child is taking or has recently taken and for what reasons:

_____

_____

List any allergy or sensitivity to medications or drugs including Penicillan, Aspirin, Latex, Sulpha or Nickel

_____

_____

Is your child currently under the care of a physician? ○ Yes ○ No
If so, for what? _____

Has your child reached puberty? ○ Yes ○ No

Child's physician _____

Is there anything regarding your child's physical, mental or emotional health that you feel we should know? _____

_____

I hereby authorize Dr. Nina Mandelman, Dr. Ahsan Raza and/or their associates to perform any and all treatment for my above named child and consent to such methods, drugs and agents as may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled.

_____ _____ _____
Signature Relationship to Child Date

PLEASE NOTE: Payment is expected for services rendered at the time of the first visit. If the family is not living together, the parent bringing the child to appointments is responsible for the account.

I HAVE REVIEWED MY CHILD'S MEDICAL HISTORY AND IT IS CORRECT. (Please initial and date in the space provided below)

INITIAL	DATE	INITIAL	DATE	INITIAL	DATE	INITIAL	DATE	INITIAL	DATE	INITIAL	DATE