CUPERTINO
Pediatric Dentistry

CHILD'S FULL NAME FIRST NAME	M.I	 LAST NAME	NICKNAME	SEX	AGE	DATE OF BIRTH

SCHOOL	GRADE	REASON FOR VISIT

REFERRED TO THIS OFFICE BY (WE WISH TO THANK THEM):

MEDICAL HISTORY

CHILD'S PHYSICIAN	CITY	PHONE #	DATE LAST SAW PHYSICIAN MONTH/YEAR

YES NO

1. IS YOUR CHILD PRESENTLY UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL PROBLEM? ☐ ☐
   WHAT? PHYSICIAN NAME & PHONE #
2. IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION? WHAT? ☐ ☐
3. HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY? FOR WHAT? ☐ ☐
4. IS YOUR CHILD ALLERGIC TO ANY FOOD OR MEDICINE? WHAT? ☐ ☐
5. HAS YOUR CHILD HAD A HISTORY OF:

YES	NO		YES	NO		YES	NO	
☐	☐	ADHD / ADD	☐	☐	CHEMO / RADIATION	☐	☐	HEPATITIS
☐	☐	ANEMIA	☐	☐	CYSTIC FIBROSIS	☐	☐	IMMUNE DISORDER
☐	☐	ALLERGIES	☐	☐	DELAYED DEVELOPMENT	☐	☐	KIDNEY / LIVER ISSUES
☐	☐	ASTHMA / BREATHING ISSUES	☐	☐	DEPRESSION / ANXIETY	☐	☐	MUSCULAR DISORDER
☐	☐	AUTISM SPECTRUM	☐	☐	DIABETES	☐	☐	PREMATURE BIRTH
☐	☐	BLEEDING DISORDER	☐	☐	DOWN'S SYNDROME	☐	☐	RHEUMATIC FEVER
☐	☐	BRAIN INJURY	☐	☐	EARACHES / INFECTIONS	☐	☐	SPEECH DISORDER
☐	☐	CANCER / MALIGNANCY	☐	☐	EMOTIONAL / SCHOOL ISSUES	☐	☐	TUBERCULOSIS
☐	☐	CARDIAC DISEASE / MURMUR	☐	☐	EPILEPSY / SEIZURE	☐	☐	VISUAL IMPAIRMENT
☐	☐	CEREBRAL PALSY	☐	☐	HEARING IMPAIRMENT			

6. DOES YOUR CHILD HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED?
   YES ☐ NO ☐
   IF SO, WHAT?

DENTAL HISTORY

CHILD'S FIRST DENTAL VISIT? YES ☐ NO ☐	PREVIOUS DENTIST CITY PHONE #	DATE OF LAST VISIT	DATE OF LAST X-RAY

ANY INJURIES TO YOUR CHILD'S TEETH OR JAWS?
(FALLS, BLOWS, CHIPS, ETC)

YES NO
☐ ☐ WHAT?

ANY HISTORY OF:
THUMB SUCKING ☐ LIP SUCKING ☐
FINGER SUCKING ☐ NAIL BITING ☐
PACIFIER ☐

HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS MEDICAL OR DENTAL CARE?
YES NO
☐ ☐ EXPLAIN:

NAME OF FAMILY DENTIST CITY PHONE #

HOW OFTEN DOES YOUR CHILD BRUSH?	IS TOOTHBRUSHING SUPERVISED? YES NO ☐ ☐	BY WHOM?

IS DENTAL FLOSS USED? YES NO ☐ ☐	DOES YOUR CHILD RECEIVE: ☐ FLUORIDE TOOTHPASTE ☐ FLUORIDE IN VITAMINS ☐ FLUORIDE TABLETS/DROPS ☐ FLUORIDATED WATER ☐ NONE

FAMILY INFORMATION

RESIDENCE ADDRESS STREET CITY ZIP CODE	PHONE #
FIRST NAMES OF ALL BROTHERS AND SISTERS AND THEIR AGES:	EMAIL:

HAS ANY MEMBER OF YOUR FAMILY
BEEN A PATIENT IN THIS OFFICE BEFORE? YES ☐ NO ☐ IF YES, NAME:

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

IS YOUR CHILD COVERED BY A DENTAL PLAN? YES ☐ NO ☐ DUAL INSURANCE? YES ☐ NO ☐ RECEIVED PREVIOUS CARE UNDER THIS PLAN? YES ☐ NO ☐

FATHER'S FULL NAME	SOCIAL SECURITY #	BIRTHDATE	DRIVER'S LICENSE #
OCCUPATION	ADDRESS AND PHONE IF DIFFERENT ( )		
EMPLOYER	BUSINESS ADDRESS CITY		BUS. PHONE #
NAME OF INSURANCE CO.	ADDRESS OF INSURANCE CARRIER		GROUP OR POLICY #
MOTHER'S FULL NAME	SOCIAL SECURITY #	BIRTHDATE	DRIVER'S LICENSE #
OCCUPATION	ADDRESS AND PHONE IF DIFFERENT ( )		
EMPLOYER	BUSINESS ADDRESS CITY		BUS. PHONE #
NAME OF INSURANCE CO.	ADDRESS OF INSURANCE CARRIER		GROUP OR POLICY #

To the best of my knowledge, all of the preceding answers are true and correct. If there is ever any change in my child's health or if my child's medicines change, I will inform the doctor of dentistry at the next appointment without fail.

I acknowledge by signing this form, I will be financially responsible for my child's account.

I hereby authorize DR. MAHNAZ GORGANI, DR. NATALIE VANDER KAM 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	PRINTED NAME	RELATIONSHIP TO PATIENT	DATE