Smile Kingdom
General Dentistry
for
Infants, Children and Teens
(916) 852-8510
2340 Sunrise Blvd., Suite 25
Rancho Cordova, CA 95670
www.smilekingdom.com

CHILD'S HISTORY

(These questions are of great value in aiding us in the treatment and better understanding of your child.)

Child's Name _____ Nickname _____

Birthdate _____ Male/Female Birthplace _____
Month - Day - Year

Parent(s)/Guardian(s) Name _____

Who is the custodial parent(s) _____

DENTAL INFORMATION:

Family dentist _____ Phone No. _____

1. Is there a particular situation you would like examined today? ☐ Yes ☐ No If "yes", explain: _____

_____

2. When was your child's last dental checkup and cleaning? _____
3. Has your child been seeing a dentist for regular checkups and care? ☐ Yes ☐ No
4. Has your child had any negative experiences with dentists or doctors? ☐ Yes ☐ No What, If any: _____

_____

5. Taking Fluoride? ☐ Yes ☐ No

MEDICAL INFORMATION:

Child's physician _____ Phone No. _____

Address _____

1. Does your child have or has your child ever had any of the following:

	YES	NO
A) Heart disease, murmur or rheumatic fever? **If yes**, antibiotic documentation will be required from patient's physician.	☐	☐
B) High or low blood pressure	☐	☐
C) Hay fever, sinus problems, or allergies	☐	☐
D) Herpes or cold sores	☐	☐
E) Diabetes	☐	☐
F) Low birth weight / premature	☐	☐
G) Autism / Autism Spectrum Disorder	☐	☐
H) Cerebral Palsy	☐	☐
I) Kidney disease	☐	☐
J) Cancer, tumors, other growths	☐	☐
K) Radiation or chemotherapy	☐	☐
L) Reactions or allergies to any of the following:	☐	☐

☐ Aspirin or other pain medication
☐ Foods ☐ Latex ☐ Antibiotics
☐ Dental anesthetics ☐ Other (food dye, etc.)
If yes to any of above, specify _____

M) Immunologic deficiency disease (Leukemia, AIDS/HIV positive, other)	☐	☐
N) Liver disease (Hepatitis, jaundice)	☐	☐

	YES	NO
O) Thyroid problems	☐	☐
P) Lung disease (TB, asthma, persistent cough, other)	☐	☐
Q) Epilepsy, seizures, fainting spells	☐	☐
R) Arthritis	☐	☐
S) Sore throats, tonsillitis, earaches	☐	☐
T) Venereal disease	☐	☐
U) Abnormal bleeding or blood disorders If yes, what _____	☐	☐
V) Smoke or use other forms of tobacco	☐	☐
W) Does your child receive regular vaccinations / immunizations	☐	☐
X) ADD or ADHD	☐	☐
Y) Behaviour and/or emotional problems	☐	☐
Z) Take any drugs or medications, prescription or non-prescription If yes, what _____	☐	☐
AA) Is your child adopted?	☐	☐
Does he/she know?	☐	☐
BB) Has your child been treated or currently being treated for any chemical dependency?	☐	☐

Any other conditions/syndromes (Example: Down syndrome, cleft lip/palate) we should be aware of? _____

FEMALES

Is there any possibility your child could be pregnant? ... ☐ ☐ Does she take birth control medication? ☐ ☐

_____ Date _____
Parent/Guardian