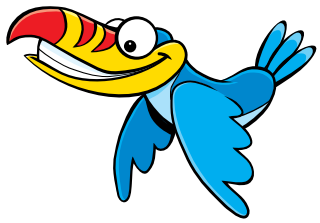
KIDS TEETH, LLC
OPHIR ALALOUF, DDS
SAMAN MADANI, DMD

OUR MISSION STATEMENT:

As a team we are committed to caring for your children as our own. We provide quality oral care and education in a fun, safe, and nurturing environment.



Child's Health History

Child's Name: _____

Pediatrician's Name: _____

Pediatrician's Phone: (_____) _____

Date of Last Visit: _____

Do you need a referral to a pediatrician? ☐ Yes ☐ No

Today's Date: _____

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

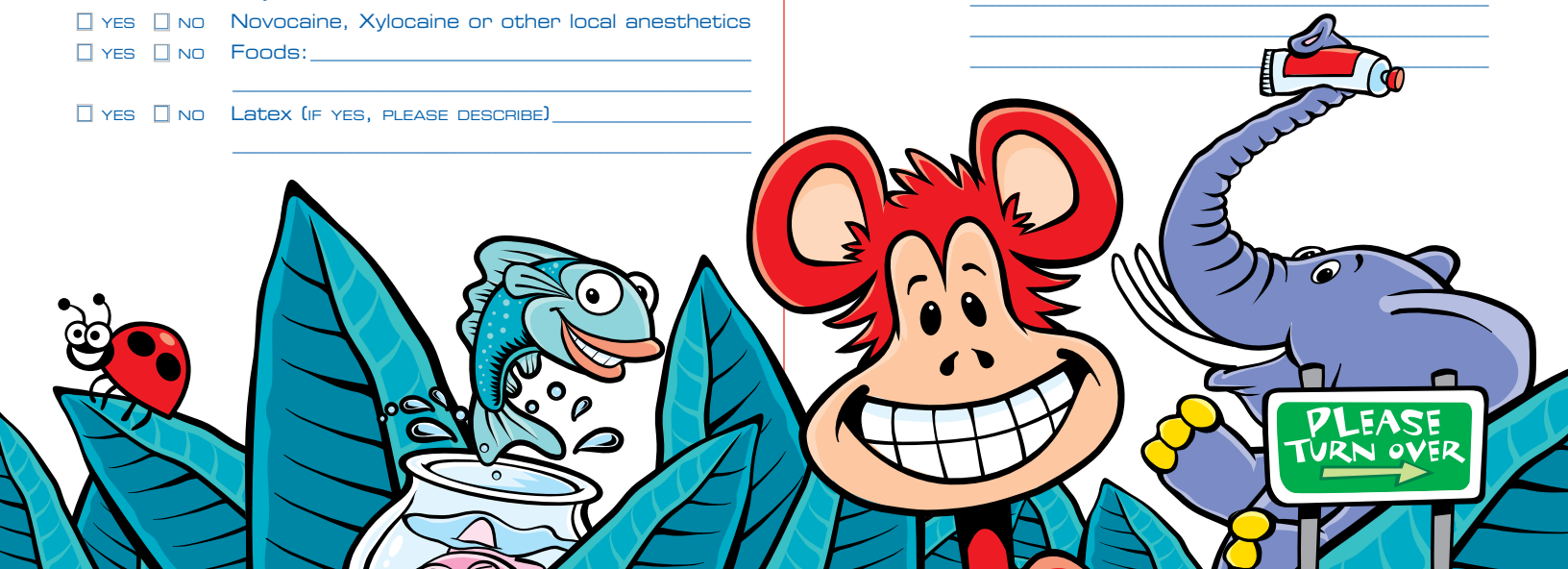
☐ YES ☐ NO Adenoids removed
☐ YES ☐ NO Artificial/ Prosthetic Joints
☐ YES ☐ NO Asthma or Breathing Problems
☐ YES ☐ NO Cardiovascular disease
☐ YES ☐ NO Congenital Heart Lesions
☐ YES ☐ NO Ear Infections (IF YES, WHAT AGE? _____)
☐ YES ☐ NO Heart Murmur (IF YES, INNOCENT? _____)
☐ YES ☐ NO Pacemaker
☐ YES ☐ NO Physician has recommended antibiotics before dental treatment
☐ YES ☐ NO Rheumatic fever or Rheumatic heart Disease
☐ YES ☐ NO Sinus Infection
☐ YES ☐ NO Tonsils removed
☐ YES ☐ NO Tuberculosis (TB)
☐ YES ☐ NO Valvular Replacements

HAS YOUR CHILD EVER HAD AN ALLERGIC REACTION TO:

☐ YES ☐ NO Aspirin or Ibuprofen
☐ YES ☐ NO Codeine
☐ YES ☐ NO Penicillin of other antibiotics _____
☐ YES ☐ NO Sulfa Drugs
☐ YES ☐ NO Other Drug Allergies not listed: _____
☐ YES ☐ NO Environmental Allergies
☐ YES ☐ NO Hay Fever or Sinus Problems
☐ YES ☐ NO Novocaine, Xylocaine or other local anesthetics
☐ YES ☐ NO Foods: _____
☐ YES ☐ NO Latex (IF YES, PLEASE DESCRIBE) _____

DOES YOUR CHILD HAVE OR DIAGNOSED WITH:

☐ YES ☐ NO Anemia
☐ YES ☐ NO Autism/Autism Spectrum Disorder _____
☐ YES ☐ NO Behavior Problems _____
☐ YES ☐ NO Blood Transfusion
☐ YES ☐ NO Cancer
☐ YES ☐ NO Convulsions/ Epilepsy/ Seizures
☐ YES ☐ NO Diabetes, Medication? _____
☐ YES ☐ NO Growth Problems
☐ YES ☐ NO Handicap/ Disabilities _____
☐ YES ☐ NO Hearing Impairment _____
☐ YES ☐ NO Hemophilia
☐ YES ☐ NO Hepatitis, jaundice or liver problems (IF JAUNDICE, WHEN NEWBORN? _____)
☐ YES ☐ NO HIV+/ AIDS
☐ YES ☐ NO Hospital Stays _____
☐ YES ☐ NO Kidney Disease
☐ YES ☐ NO Learning Problems _____
☐ YES ☐ NO Low/ High Blood Pressure
☐ YES ☐ NO Mental/ Emotional Problems _____
☐ YES ☐ NO Pregnant
☐ YES ☐ NO Sensory Integration
☐ YES ☐ NO Sickle Cell Anemia (HAVE THEY EVER BEEN TESTED? _____)
☐ YES ☐ NO Stomach ulcers
☐ YES ☐ NO Thyroid Problems
☐ YES ☐ NO Any Operations _____
☐ YES ☐ NO Under Physicians Care (IF YES, PLEASE DESCRIBE)
☐ YES ☐ NO Taking any medications (IF YES, PLEASE LIST): ___



Child's Dental Health History

Purpose of today's visit: _____

_____

How long has it been since your child's:

LAST DENTAL EXAM? _____

LAST TOOTH CLEANING? _____

FIRST VISIT EVER? _____

☐ YES ☐ NO Does your child brush his/her teeth daily?

☐ YES ☐ NO Do you have difficulty brushing and/or flossing? If yes, please explain: _____

_____

For most drinking & cooking do you use:

☐ TOWN WATER ☐ WELL WATER ☐ BOTTLED WATER

☐ YES ☐ NO If "well" or "bottled", has water been tested for fluoride?
What were the results? _____

☐ YES ☐ NO Does your child take fluoride supplements?
Dose: _____
Frequency: _____

☐ YES ☐ NO Have there been any injuries to the face, mouth, or teeth? If yes, please give descriptions: _____

_____

☐ YES ☐ NO Has your child ever sucked thumb, fingers, or pacifier? (IF YES, PLEASE CIRCLE)
Until what age? _____

_____

☐ YES ☐ NO Any other habits? _____

_____

_____

☐ YES ☐ NO Was your child nursed? If yes, until what age? _____

☐ YES ☐ NO Has your child used a bottle? If yes, until what age? _____

☐ YES ☐ NO Did your child go to sleep while nursing or with a bottle? If yes, until what age? _____

DOES YOUR CHILD HAVE:

☐ YES ☐ NO Bad Breath

☐ YES ☐ NO Snoring

☐ YES ☐ NO Daytime Mouth Breathing

☐ YES ☐ NO Nighttime Mouth Breathing

☐ YES ☐ NO Tooth Grinding

☐ YES ☐ NO Bedwetting Now

☐ YES ☐ NO History of sleep apnea

☐ YES ☐ NO Restless Sleep

☐ YES ☐ NO Frequent middle ear infections

☐ YES ☐ NO Speech Problems

☐ YES ☐ NO Have you been informed of any missing or extra permanent teeth?

☐ YES ☐ NO Are there any unusual sounds in ear (clicking) while eating?

☐ YES ☐ NO Is your child concerned about the appearance of his/her teeth?

☐ YES ☐ NO Has your child ever had an orthodontic examination or treatment?

☐ YES ☐ NO Has your child ever had a bad experience with previous dental appointment? If yes, please explain: _____

☐ YES ☐ NO Is your child nervous or frightened about coming to the dentist?

☐ YES ☐ NO Does your child participate in sports? If yes, please list: _____

_____

☐ YES ☐ NO Does your child wear a mouthguard?

Certification

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I also understand that it is my responsibility to inform this office of any changes in my child's health status and/or medications. I will not hold Kids Teeth, LLC responsible for any complications arising from errors or omissions that I may have made in the completion of this form.

Signature: _____

Date: _____

OFFICE USE ONLY:

I verbally reviewed the medical and dental information above with the parent/guardian and patient.

Initials: _____ Date: _____

Comments: _____

_____

_____

_____

_____