Sydney J. Moore, DDS – K. Ann Moore, DDS – Jack L. Moore, DDS
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(916) 782-1209

PATIENT HEALTH NFORMATION

Patient Name: ____ Nickname:_________________
Sex: Male [ ] Female [ ] Date of Birth _____/_____/_____
School Attending: ______________________________________ Grade:_____________________
Favorite Pet, Toy or Activities: ____
Siblings or Relatives Who are Patients: ____
Who may we thank for referring you? ____

Reason for Visit: 1. Relief of pain: ___ 2. Complete Dental Care: ____ 3. Other: _______________
Child's Pediatrician or Physician: _____________________________ Phone: _________________
Previous Dentist: ____ Phone: _________________

HEALTH HISTORY

Is your child in good health?	yes__ no__	Does your child have regular medical exams?	yes__ no__
Is this your child's first dental visit?	yes__ no__	Has your child had injuries to teeth or mouth?	yes__ no__
Is your child taking dietary fluoride?	yes__ no__	Does your child suck their thumb, fingers or pacifier?	yes__ no__
Does, or did your child sleep with a bottle?	yes__ no__	Has been hospitalized, had surgery or blood transfusions?	yes__ no__
Does your child have a learning disability?	yes__ no__	If age or gender appropriate, is the child pregnant?	yes__ no__

Does your child have a history of:

Heart Condition	yes__ no__	Asthma	yes__ no__	Mental Disorders	yes__ no__
Rheumatic Fever	yes__ no__	Lung Disease	yes__ no__	Emotional Disorder	yes__ no__
Bleeding Disorder	yes__ no__	Tuberculosis	yes__ no__	Depression	yes__ no__
Sickle Cell disease	yes__ no__	Allergies	yes__ no__	Autism	yes__ no__
Kidney Disease	yes__ no__	Tumors	yes__ no__	Nervous Disorder	yes__ no__
Liver Disease	yes__ no__	Brain Damage	yes__ no__	Hyperactivity/ ADD	yes__ no__
Hepatitis	yes__ no__	Speech Disorder	yes__ no__	Bed Wetting	yes__ no__
Diabetes	yes__ no__	Hearing Disorder	yes__ no__	Infections	yes__ no__
Allergies to Medicines	yes__ no__	Vision Disorder	yes__ no__	HIV / AIDS	yes__ no__
Allergies to Latex	yes__ no__	Epilepsy	yes__ no__	Other (Explain Below)	yes__ no__

If you answered **yes** to any of the Health History questions, please explain: ______________________
____
Medications or Herbal Supplements your child is currently taking: _____________________________
____

Has your child had any unusual or unpleasant experiences in a medical or dental office? yes__ no__
If yes, please explain: ____
____
Do you have any special concerns, which you would like to discuss with the doctor? _______________
____

Because your child is a minor, signed permission from a parent or guardian must be obtained before any dental treatment is started.
Signature: ____________________________ Date: ______________ Relationship: ______________

<<< Thank you for choosing our office. All information will be strictly confidential >>>

Reviewed and updated _________________ Reviewed and updated ________________
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