2360 gulf freeway south, Suite 106, League-city, TX 77573. Ph: 281-337-3222. Fax 281-337-9222

Welcome. We offer you friendship & extraordinary Pediatric Dental & Orthodontic care.

Please fill in your answers as thoroughly as possible. This will help in developing a complete dental health program for your child. Of course, all information will be held in strict confidence.

By working together, we can find a way to achieve your goal of good dental health and beautiful smiles for your child, in ways that transform the quality of life for your child & for you. Come for the dentistry. Stay for the friendship!

PATIENT INFORMATION: Date: ____

Patient's Name:____ ____________________
First Middle Last

Nickname_______________________________________ Date of Birth___/___/___ Sex: ❑female ❑male

Home Street Address____ Home Phone Number________________________

City____ Zip________________________________

School____ Grade____________________________________

Phone Number for appointment reminder: ____

MOTHER'S NAME____
First Middle Last

Home Street Address____ Home Phone Number________________________

Social Security Number_________________________ Mother's DOB ____________________ Occupation____________________

E-mail address ____Employed by________________________________

Business Address ____Business Phone______________________

FATHER'S NAME____ __________________
First Middle Last

Home Street Address____ Home Phone Number________________________

Social Security Number_________________________ Father's DOB ____________________ Occupation____________________

E-mail address ____Employed by________________________________

Business Address ____Business Phone______________________

Who is your family dentist?____________________________________Office located in what city?_________________

Whom may we thank for referring you? ____

Referring address ____

- **Federal law requires that the parent or guardian who brings the child to appointments is responsible for the incurred fees.**
- **I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.**
- **I certify this information is true and correct to the best of my knowledge.**
- **I will notify you of any changes in my child's health status or the above information.**
- **I understand Doyle & Baker, PSC files insurance claims electronically. This is acceptable to me.**
- **I have received my brochure about my privacy rights (HIPAA) and how my information can be used.**

____ Date_____________________
Signature relationship to patient

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DENTAL HEALTH:

Why did you bring your child to the dentist today?____

How long has it been since your child's last dental exam?________________last tooth cleaning?_______________ ❑First visit ever

For most drinking & cooking do you use: ❑town water ❑well-water ❑bottled water

If well or bottled, has water been tested for fluoride?...❑No ❑Yes

Results? ____

Does your child take fluoride supplements?...❑Yes ❑ No

Dose____Frequency______________

Have there been any injuries to the face, mouth or teeth?...❑Yes ❑ No

Please give dates and descriptions____

____

Has your child ever sucked a thumb or fingers?...❑Yes ❑ No

Pacifier?...*❑Yes ❑ No

Any other habits?____________________ For thumb, pacifier or other habits until what age?________

Does your child have:

- Snoring ....*❑Yes ❑ No
- Daytime mouthbreathing ....*❑Yes ❑ No
- Nighttime mouthbreathing ....*❑Yes ❑ No
- Tooth grinding ....*❑Yes ❑ No
- Bedwetting now ....*❑Yes ❑ No
- Hearing deficiency ....*❑Yes ❑ No
- Frequent middle ear infections ....*❑Yes ❑ No
- Environmental allergies ....*❑Yes ❑ No
  - Taking medications?____
- History of sleep apnea...*❑Yes ❑ No
- Restless Sleep …………………………………………………………………………………….. *❑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) during eating? .... ❑Yes ❑ No

Has your child ever had an orthodontic examination or orthodontic treatment?... ❑Yes ❑ No

Does your child use a sippy cup? ....*❑Yes ❑ No

Did your child go to sleep with a bottle, with a sippy cup, or while nursing ?...*❑Yes ❑ No

Until what age?____

Is your child nervous or frightened during dental visits? If yes, please circle

Least Nervous 0 1 2 3 4 5 6 7 8 9 10 Most Nervous

It would be helpful if you would indicate below what things you are looking for most in choosing a pediatric dentist.

____

Has your child had any unfavorable medical or dental experience?..❑Yes ❑No

If so, please explain____

How will you describe your child's temperament (please circle one):

Easy or Flexible   Active or Feisty   Slow to warm or Shy   Other ____

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MEDICAL HEALTH:

Is your child in good health?..❑No ❑Yes

Date of last physical examination____

Is your child now under the care of a physician?..❑Yes ❑No

If so, what is the condition being treated?____

Did your child have trouble at birth or during the early years?...❑Yes ❑No

Please describe____

Name of Pediatrician or Family Physician____

Address & Phone ____

Has your child had any serious illness or injury?...❑Yes ❑No

If so, what was the illness or injury? _________________________________Date_______

Was your child delivered by Caesarean Section?...❑Yes ❑No

Has your child ever been hospitalized or had surgery? ....❑Yes ❑ No

DATE___________________REASON:_____________________________________

DATE___________________REASON:_____________________________________

Have your child's tonsils or adenoids been removed? ....❑Yes ❑ No

If yes, when____

What is the teeth decay rate of your child's siblings? ❑none ❑slight ❑moderate ❑severe

Does your child have or has your child had any of the following?

Rheumatic fever or rheumatic heart disease ❑Yes ❑No
Heart murmur ❑Yes ❑ No
Congenital heart lesions ❑Yes ❑ No
(heart abnormalities present since birth) ❑Yes ❑ No
Physician has recommended antibiotics before dental procedures ❑Yes ❑ No
Other cardiovascular Disease ❑Yes ❑ No
Environmental allergies *❑Yes ❑ No
Hay fever or sinus problems *❑Yes ❑ No
Asthma or breathing problems *❑Yes ❑ No
Hives or skin rash ❑Yes ❑ No
Fainting spells or seizures ❑Yes ❑ No
Diabetes ❑Yes ❑ No
Hepatitis, jaundice or liver problems ❑Yes ❑ No
(if jaundice, when newborn?) ❑Yes ❑ No
Arthritis ❑Yes ❑ No
Limits on physical activities ❑Yes ❑ No

Tuberculosis ❑Yes ❑ No
Mononucleosis ❑Yes ❑ No
Low blood pressure ❑Yes ❑ No
Thyroid problem ❑Yes ❑ No
Anemia ❑Yes ❑ No
Bone disorders ❑Yes ❑ No
Growth problems ❑Yes ❑ No
Stomach ulcers ❑Yes ❑ No
Kidney problems ❑Yes ❑ No
Birth defect (please describe):_______
____
Hearing problems ❑Yes ❑ No
Learning problems *❑Yes ❑ No
Behavior problems *❑Yes ❑ No
Mental/emotional problems ❑Yes ❑ No
Blood transfusion ❑Yes ❑ No
HIV (AIDS) ❑Yes ❑ No
Other ❑Yes ❑ No
____

Has your child had abnormal bleeding with previous extractions, surgery, or trauma? ....❑Yes ❑ No

Has your child been tested for sickle cell anemia? ....❑Yes ❑ No

If yes, what was the result?____

Does your child take any drug or medicine? ....❑Yes ❑ No

If so, what/how often_________________________

Does your child take any vitamins, supplements? ....❑Yes ❑ No

Please list:____

Has your child ever had an allergic reaction to:(if yes, please describe)___________________________

Aspirin or Ibuprofen	Yes	No	Codeine	❑Yes	❑ No
Penicillin or other antibiotics	Yes	No	Sulfa drugs	❑Yes	❑ No
Novocaine, Xylocaine or			Foods	❑Yes	❑ No
other local anesthetics	Yes	No	Latex	❑Yes	❑ No

Other_____________________________________

Does your child use any complementary or alternative medicines or supplements? .... ❑Yes ❑ No

Please list ____

Does your child have any mental or physical disability? .... ❑Yes ❑ No

If so, please explain____

Does your child have any disease, condition or problem not listed above that you think we should know about?

____

What are her/his hobbies or interests?

____

Thank you very much!

Name of Parent/ Guardian ____

Signature of Parent/Guardian ____

Relationship to Patient ____

Date: ____

CONSENT:

l. The undersigned hereby authorizes the taking of x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Mbibi to make a thorough diagnosis of your child's dental orthodontic needs.

2. I also authorize Dr. Mbibi to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment of my child.

3. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Dr. Sandra Mbibi choose and employ such assistance as deemed fit to provide recommended treatment.

Name of Parent/ Guardian ____

Signature of Parent/Guardian ____

Relationship to Patient ____

Date: ____