We Would Like to Get to Know You Better!

Date:___________

Full Name____ Phone (Hm) ___________________ (Wk) __________________

Address____ City____________________________ State _____ Zip_________

Email__________________________________ Date of birth_____________________ Social Security #______________________

Drivers License #________________ Marital status___________ Spouse's name____

Occupation__________________________ Employer____ Work Hours____________

Contact in case of emergency ____ Phone ___________________

When was your last dental appointment? ______________ Person responsible for your dental investment________________________

How did you hear about us? __________________ Why did you leave your last dentist? ___________________________________

We Want to Take Care of Your Concerns and Needs First…

What are your present dental problems? ___________________________________

Do you avoid brushing any part of your mouth? Yes No

Do your gums bleed when brushing? Yes No

Are your teeth sensitive to sweets, hot/cold, or biting pressure? Yes No

I want to know about longer lasting solutions that may cost more. Yes No

Are you dissatisfied with your teeth and their appearance? Yes No

Does dental treatment make you nervous?
No Slightly Moderately Very

I think my dental health is…
Excellent Good Fair Poor

If I could change my smile I would make my teeth…
Whiter Straighter Close Spaces Repair Chips

Other concerns/needs of mine are ____

For Insurance Purposes…

Name of policy holder_______________________________________ Policy holder Social Security # ________ - _____ - _________

Policy holder's date of birth_____________ Employer_________________________ Name of ins. co.__________________________

Insurance company's Phone__________________ Group #_____________ Ins. Co. Address_________________________________

Are you covered by another plan? If so please complete the following…

Name of policy holder_______________________________________ Policy holder Social Security # ______________________

Policy holder's date of birth_____________ Employer_________________________ Name of ins. co.__________________________

Insurance company's Phone__________________ Group #_____________ Ins. Co. Address_________________________________

Rajneesh K. Dail, D.D.S. Betsy Duell, D.D.S.
Diplomates of the American Board of Pediatric Dentistry
Morgan Hill Dental Care
18455 Technology Drive, Morgan Hill, CA 95037 (408)778-4838

Members of

Date________

HEALTH HISTORY

Patient's Name________________ (first) ________________ (last)

Birthdate________ Boy Girl (please circle)

Patient's Physician________________ Phone________

Address________________ Date last saw physician________

Patient's Specialist________________ Phone________

Is/Has Child:	Yes	No	If yes:
Any illness now?	☐	☐	Type________
Receiving any medications or drugs?	☐	☐	List________
Ever been hospitalized?	☐	☐	Date________
Ever had surgery?	☐	☐	Date________
Allergic to any medications?	☐	☐	List________
Allergic to latex products?	☐	☐	List________
Are there any other allergies?	☐	☐	List________
Born Premature or Low Birthweight?	☐	☐	Explain________

Has/Had any history of:

(please circle)

Anemia	Y	N	Hearing Problem	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Heart Problem	Y	N	Sleep Apnea	Y	N
Autism	Y	N	Heart Murmur	Y	N	Tuberculosis	Y	N
Bleeding Disorder	Y	N	Hepatitis	Y	N	Tumors/Cancer	Y	N
Diabetes	Y	N	HIV/AIDS	Y	N	Special Needs/Other:________		
Emotional Problem	Y	N	Kidney Disease	Y	N	________		
Epilepsy/Convulsions	Y	N	Liver Disease	Y	N	________		
Fainting or Diziness	Y	N	Mental Disorder	Y	N	________		

DENTAL HISTORY

Reason for this appointment________________

How do you feel about the condition of your child's mouth and teeth?________________

Date of last visit________ Name of former dentist________________

Treatment provided________________

Has Child:	Yes	No	If yes:
Complained about dental problems?			________
Has had an unhappy Dental Experience?			________
Had any injuries to mouth, teeth or head?			________
Had nursing, bottle feeding or bottle habits continue beyond 18 months of age?			________
Had any mouth habits such as thumbsucking, nail-biting, mouth breathing, pacifier, etc.?			________
Is Fluoride taken in any form?			________
Had adverse reaction to anesthetics?			________

Child's attitude toward dentistry ________________

Parent or Guardian Signature________________**Relationship to Child**________ **Date**________

Reviewed on/by ________