



GET ACQUAINTED QUESTIONNAIRE
Ximena Pareja, DDS Pediatric Dentistry



Child's Name _____ Nickname _____ Age _____ Date of Birth _____

Father's Name _____ Mother's Name _____

Permanent Address _____

City _____ State _____ Zip _____ Phone _____

- Father's Employment - _____ Employer _____
- Mother's Employment - _____

Occupation _____

Business Address _____

Phone _____

Social Sec. No. _____

DOB _____

Dental Insurance Coverage, Name of Carrier _____

Name of Group Dental Program _____

Group Number _____

Parent's Marital Status (X): Married _____ Single _____ Widowed _____ Separated _____ Divorced _____

Person Responsible for Child's Account _____ Relationship _____

Address (if different) _____

Whom may we thank for referring your child to us? _____

If not referred, how did you hear of us? _____

List Names and Ages of Brothers and Sisters _____

Child's School _____ Grade _____

What is your child's favorite: School Subject _____

Pet _____ TV Shows _____

Sport _____ Hobbies _____ Person _____

DENTAL HISTORY

Date of last visit to a dentist _____		Any unusual speech habits? _____	Yes	No
			<input type="checkbox"/>	<input type="checkbox"/>
For what service? _____		Orthodontic appliances worn now or ever been _____	<input type="checkbox"/>	<input type="checkbox"/>
Name of previous dentist _____		Does your child brush teeth daily? _____	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	Do you assist child with tooth brushing? _____	<input type="checkbox"/>	<input type="checkbox"/>
	No	Is dental floss used? _____	<input type="checkbox"/>	<input type="checkbox"/>
May we request previous records? _____	<input type="checkbox"/>	Is fluoride taken in any form? How? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has child complained about dental problems? _____	<input type="checkbox"/>	Child's attitude to dentistry _____		
_____		Do you anticipate your child having difficulty accepting		
Any unhappy dental experiences? _____	<input type="checkbox"/>	dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
_____		Do you desire complete dental service for the child? _____	<input type="checkbox"/>	<input type="checkbox"/>
Any injuries to mouth, teeth, head _____	<input type="checkbox"/>	Are there any dental problems bothering your child at this time? _____	<input type="checkbox"/>	<input type="checkbox"/>

Any mouth habits - thumbsucking, finger sucking, mouth breathing, nursing bottle habits, pacifier (Circle) _____	<input type="checkbox"/>			
	<input type="checkbox"/>			

HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

Is child under care of physician now? Why? _____ YES NO Has child ever been hospitalized? Why? _____ YES NO

Is child receiving any medication or drugs? What? _____ Does child have good physical coordination? _____

Is there any excessive bleeding when cut? _____ Are there any emotional or nervous problems? Explain:

• IS YOUR CHILD ALLERGIC TO:

PENICILLIN _____ ANTIBIOTICS _____ LOCAL ANESTHETIC (NOVOCAINE) _____

ASPIRIN _____ FOODS _____ LATEX _____ OTHER _____

• DOES YOUR CHILD HAVE ANY HEALTH PROBLEMS THAT YOU WOULD LIKE TO TALK ABOUT PRIVATELY WITH THE DENTIST? YES NO _____

• Does your child have or ever had any of the following? (Please place X and explain below):

- | | | | |
|--------------------------------------|---------------------------|-----------------------------|------------------------|
| _____ Anemia | _____ Cleft Lip or Palate | _____ Heart Problems | _____ Rheumatic Fever |
| _____ Asthma | _____ Convulsions | _____ Jaundice | _____ Sight Problems |
| _____ Bladder Problems | _____ Diabetes | _____ Kidney Problems | _____ Speech Problems |
| _____ Blood Disorders | _____ Epilepsy | _____ Liver Problems | _____ Thyroid Problems |
| _____ Cerebral Palsy | _____ Fainting | _____ Mental Retardation | _____ Tuberculosis |
| _____ Chronic Sinus | _____ Hearing Problems | _____ Murmurs | _____ Other |
| _____ HIV / AIDS | _____ High Blood Pressure | _____ Mitral Valve Prolapse | _____ Pacemaker |
| _____ Artificial / prosthetic joints | | | |

EXPLAIN: _____

ADDITIONAL COMMENTS: _____

Since this patient is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any dental service can be performed. Authorization is hereby granted as such. Furthermore, I will be responsible financially for any bill incurred on the patient for dental treatment or, if I indicated someone else is responsible, permission is granted for verification. Please be advised that there is a \$50.00 charge for broken appointments without 24 hours notice.

Signature _____

Relationship to Child _____

Thank you for giving us the privilege of seeing your child. We are anxious to provide the best possible care. The answers to these questions will help make this possible. Thank You For Your Cooperation!