EDUARDO CORREA, D.D.S.
pediatric dentistry

Welcome! We are pleased to welcome you and your child to our practice and dental family. Please help us to get to know you better by taking a few minutes to fill out this form as completely as you can. Today's Date: _____

***How did you choose our office/To whom may we thank for referring you**?:* _____

Patient Information

Name of Child: ____ _____M__F__ Nickname: _____ DOB: _____ Age: ____

Address:_____ City:_____ Zip:_____

What school does your child attend? _____ Siblings (Name, age):_____

Hobbies/ interests: _____

Do you know any other children that come to our office? If yes, please list names: _____

Is your child covered by dental insurance? Yes No If so, please list: _____

Reason for today's visit:_____ _____

Is your child in pain or in need of treatment? □ **Y** □ **N** ***Area of concern***:_____

Medical History

Child's pediatrician:_____ Date of last exam:_____
Address: _____City: _____Ph #:_____
Is your child in good health? □ **Y** □ **N** Are your child's immunizations up to date? □ **Y** □ **N**
Is your child presently under the care of a physician for any *diagnosed* medical problems? □ **Y** □ **N**
Is your child currently taking any medications? □ **Y** □ **N**
Please list:_____
Has your child ever been hospitalized or had surgery? □ **Y** □ **N**
Please explain:_____
Has your child ever had an unfavorable reaction to any of the following?
Antibiotics? □ **Y** □ **N** Local Anesthetic? □ **Y** □ **N** Latex ? □ **Y** □ **N** Other food, medication, metal allergy? □ **Y** □ **N**
If "yes", for what and how?_____
Was your child born full-term? □ **Y** □ **N** If no, how early was your child born: _____ weeks
During your pregnancy, were you sick, hospitalized, take medications, or any other issues while expecting? □ **Y** □ **N**
Please explain:_____

****Please circle if your child had history of any of the following**:

Anemia	Diabetes	Cerebral Palsy
Acid reflux	Kidney/ Liver problems	Down Syndrome
Heart problems	Seizures/ Convulsions	GI/Colon/Bladder Disorders
Cleft lip/palate	Seasonal Allergies	Sight/ Hearing Limitations
Heart murmur	Brain Injury	Mental/ Emotional Problems
Blood disorders	Autism/ ASD/Asperger's	Asthma/ Breathing Problems
Tuberculosis	ADD / ADHD	Cancer or tumors
Chromosomal Abnormality	Learning disability	Tuberculosis
Developmental Delay	Aggressive behavior	Chronic Ear Infections
"Syndrome" Diagnosis	Hepatitis/Liver disease	Other condition(s) _____

If **"yes"** to any question, **please explain**: _____
Is there anything else regarding your child's **physical, mental, or emotional health** that you feel we should know?
_____

□ **YES!- I would like to receive Dr. Eddie's quarterly newsletter: practice news, events, dental and medical health tips**

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Dental History

Is this your child's first visit to a dentist? □ **Y** □ **N** If no, when was the last exam? _____
Name of Previous Dentist: _____ City: _____
Reason for leaving previous dentist: _____
Has your child ever had an unfavorable experience at a dental office? □ **Y** □ **N**
Please explain:_____
Was your child bottle fed? □ **Y** □ **N** If yes, until what age? _____
Was your child breast fed? □ **Y** □ **N** If yes, until what age? _____
Does your child drink milk or juice to bed? □ **Y** □ **N** If yes, until what age? _____
Is/Does your child use a sippy cup? □ **Y** □ **N** Drink tap water? □ **Y** □ **N** Bottled/filtered water? □ **Y** □ **N**
Does your child use fluoride toothpaste? □ **Y** □ **N** Is your child taking any fluoride supplements? □ **Y** □ **N**
Does the child take daily vitamins? □ **Y** □ **N** If yes, circle one: Liquid vitamins Chewable vitamins Gummi Vitamins
Does your child brush daily? □ **Y** □ **N** Does your child use floss? □ **Y** □ **N** Does your child brush/floss alone? □ **Y** □ **N**
Do you experience difficulty in brushing or flossing your child's teeth?: □ **Y** □ **N**
Please explain:_____
Do you or your child's parent, caretaker, or siblings have a history of dental treatment/problems?: □ **Y** □ **N**
If yes, circle all that apply: active decay history of fillings/crowns extracted or missing teeth

**** Please circle if your child eats or drinks the following *daily and/or in between meals*:**

Juice/Fruit Drink: _____ oz/cups /day	Gummi Fruit Snacks / Gummi vitamins
Chocolate milk: _____ oz/cups /day	Chips / Crackers / Cookies
Sports Drinks: _____ oz/cups /day	Candy / Taffy / Chewy Granola
Soda Pop: _____ oz/cans /day	Fruit Roll Ups / Fruit Leather

**** Please circle if you child has or had history of:**

Toothaches	Trauma to tooth/face	Lip/Cheek biting
Jaw pain	Sensitivity to hot/cold	Current Pacifier Habit
Bleeding gums	Bad Breath	Finger Habit
Mouth breathing	Clenching/grinding	Tongue thrust
Sensitivity to sweets	Orthodontics	Self-Injurious Behavior

Parent/Guardian Information

PARENTS NAME:_____ **DOB:_____ M__F__**
Marital status: (circle) Single Married Partner Divorced Separated Widowed
Address (if diff):_____
Home Ph:_____ Cell ph:_____ Bus Ph:_____
SS#:_____ Email:_____
Employer:_____ Occupation:_____

PARENTS NAME:_____ DOB:_____ M__F__
Marital status: (circle) Single Married Partner Divorced Separated Widowed
Address (if diff):_____
Home Ph:_____ Cell ph:_____ Bus Ph:_____
SS#:_____ Email:_____
Employer:_____ Occupation:_____
Whom does the child live with?_ _____Person financially responsible _____
Legal guardian (if not parent):_____Relationship to child _____

I have reviewed the above to be correct to the best of my knowledge.
Parent/Guardian Signature _____ Date _____
Dr. Signature _____
Thank you for your time! Your answers will help us better provide for your child.