Ricardo A. Perez, D.D.S, P.C

Medical History

We are pleased to welcome you to our office. Please take a few moments to complete this form on the front and back. If you have any questions we'll be glad to assist you. We look forward to working with you in maintaining your child's oral health.

Patient Information

Name of minor/child: _____ (_____)
Last First MI Preferred name

DOB: ____/____/____/ Age: _____ Male ◯ Female ◯ Alternate phone#: (_____) _____-_____

Home address: _____
Street #/Name City State Zip

Name of school: _____Grade: _____

Special Interests/ Fictional Characters: _____

Sibling names: _____ Age: _____
_____ Age: _____
_____ Age: _____
_____ Age: _____

Who may we thank for referring you to our office: _____

Phone No. (_____)_____-_____

Father's/Guardian's

Name: _____
Married Single Divorced/Separated Deceased

Home address: _____
(If different from patient)

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____

Employer: _____ Work Phone: (_____) _____-_____

DOB: ____/____/____ Email: _____

Mother's/Guardian's

Name: _____
Married ☐ Single ☐ Divorced/Separated ☐ Deceased ☐

Home Address: _____
(If different from patient)

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____

Employer: _____Work Phone: (_____) _____-_____

DOB: ____/____/____ Email: _____

Please see back

Dental and Medical History

Reason for today's visit: _____

Has your child ever had their teeth professionally cleaned? No ◯ Yes ◯

Date (approximate) of last cleaning: ____/____/____ Were x-rays taken? No ◯ Yes ◯

Has your child ever experienced an unfavorable reaction to dental care? No ◯ Yes ◯ _____

_____

Does your child have/had any of the following oral habits? Thumb/finger or Pacifier ☐ to age _____

Is your child under orthodontic care? No ◯ Yes ◯ Dr. _____

Has your child had a serious illness or operation? No ◯ Yes ◯ _____

_____

_____

***Primary Physicians name*:** _____ Phone No. (_____)_____-_____

Please check if your child has/had been diagnosed with any of the following:

- ☐ AIDS / HIV positive
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cough (persistent)
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ Food Allergies: _____
  _____
- ☐ Heart murmurs
- ☐ Heart problems: _____
  _____
- ☐ Hemophilia / Abnormal Bleeding
- ☐ Hepatitis
- ☐ Jaw pain
- ☐ Kidney Disease or Malfunction
- ☐ Liver Disease
- ☐ Material Allergies: _____
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Rheumatic / Scarlet Fever
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Surgical Implant
- ☐ Tuberculosis / TB
- ☐ Other (please explain):_____
  _____
  _____
  _____

I have read the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Perez to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform Dr. Perez.

Late Cancellation Policy

A great deal of planning is done for your appointment. Changes and cancellations to our schedule without adequate notice are very disruptive to our office, and to other patients waiting for appointments. For this reason, we ask that any changes to your appointments be made AT LEAST 48 HOURS in advance and 72 HOURS if appointment is on a Monday or Tuesday. If this policy is not followed a $100 fee per appointment will be charged to your account, paid prior to rescheduling.

_____ _____/_____/_____

Signature Relationship Date