TO ASSIST US IN KEEPING YOUR RECORDS UP TO DATE, PLEASE FILL THE FOLLOWING OUT COMPLETELY

Today's Date:________________

Child's Name:_________________________________Sex:_______Age :_____DOB:________________

Address ____
Street City Zipcode

For important updates, join our E-mail: __________________________ Home Phone: ________________

Cell Phone: Mom ________________ OK to Text: Y/N Dad: ___________________ OK to Text: Y/N

Father's Info: Employer__________________Phone#____________ Insurance:________________________

Mother's Info: Employer_________________Phone#____________ Insurance:________________________

1. Has your child's medical history changed since your last visit? Yes___ No ___ If yes, explain_______________
2. Has your child ever received a blood transfusion or blood products? Yes___ No___ When________________
3. Does your child have allergies or sensitivities to any drugs or medications and /or allergies to latex rubber?

   Yes_____ No ______ If so, what? ____
4. Is your child taking any medications at present? Yes____No____ If so, what? __________________________
5. Is your child presently being seen by a physician for a particular problem?

   Yes____No____ If so, what? ____
6. Are there any areas in your child's mouth that cause pain or discomfort?

   Yes____No ____Where?______________________How Long?____
7. Are there any questions about your child's dental health that we can answer today?

   Yes___No_____ If so what? ____

In compliance with Cal-OSHA Title 8, Section 5199, dental facilities must pre-screen patients for aerosol transmissible diseases (ATD). In our office we use this form to pre-screen a patient before any dental procedure is performed to determine whether the patient may present an ATD exposure risk. Does your child have:

A history of Tuberculosis?	Yes __ No __	Vomiting or Diarrhea:	Yes __ No __ How Long? ________
Bloody Sputum?	Yes __ No __	Fever:	Yes __ No __ How Long? ________
Night Sweats	Yes __ No __	Fatigue	Yes __ No __
Unexplained weight loss	Yes __ No __	Malaise	Yes __ No __
Runny Nose:	Yes __ No __ How Long? _____	Body Aches:	Yes __ No __ How Long? ________
Headache:	Yes __ No __ How Long? _____	Sore Throat:	Yes __ No __ How Long? ________
Severe coughing spasms:	Yes __ No __ How Long? _____	Fever w/respiratory symptoms:	Yes __ No __ How Long? ________
Painful, swollen glands:	Yes __ No __ How Long? _____	Nausea:	Yes __ No __ How Long? ________
Skin rash, blisters:	Yes __ No __ How Long? _____	Stiff neck, mental changes:	Yes __ No __ How Long? ________
Symptoms of Tuberculosis?	Productive cough (> 3 weeks)	Yes __ No __	

Flu or other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis? __________________

If yes to any of the above, please explain: ____

Chronic Respiratory Diseases (NOT ATD and not considered infectious) do not disqualify a patient from treatment under California OSHA Title 8, Section 5199: Does your child have:

Asthma?	Yes ___ No ___	Chronic upper airway cough syndrome "postnasal drip"?	Yes ___ No ___
Allergies?	Yes ___ No ___	Gastroesophageal reflux disaease (GERD)?	Yes ___ No ___
Chronic obstructive pulmonary disease?	Yes ___ No ___	Bronchitis?	Yes ___ No ___
Emphysema?	Yes ___ No ___	Dry cough from ACE inhibitors?	Yes ___ No___

Sign: ____
(Parent/legal guardian)