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

Home Phone: ____________________________________ E-mail: ____

Cell Phone: Mom ____________________________ Text (Y/N) Dad: _____________________________ 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? ____

I have received a copy of this office's Financial Arrangement Policy

Print Name:____ Signature: ____

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)