Jennifer Ortega D.M.D. P.A

Child's Name: _____ Nickname: _____ Date of Birth: _____
Parent Name: _____ Phone # _____
Address: _____
Child's Physician/Pediatrician: _____ Phone # _____

Yes○ No○ Is your child in good health? Date of last physical exam _____
Yes○ No○ Has your child ever had a health problem? _____
Yes○ No○ Is your child allergic to anything? If yes, what? _____
Yes○ No○ Is your child currently taking any medications? Please give medication, dose, and reason:
_____
Yes○ No○ Are your child's immunizations current?
Yes○ No○ Has your child ever been hospitalized, had general anesthesia, or emergency room visits?
Please explain: _____

Please check if your child has been treated for any of the following:

☐ Heart Disease	☐ Asthma/breathing	☐ Speech/hearing	☐ Seizures
☐ Heart Murmur	☐ Cleft lip/palate	☐ ADHD/ADD	☐ Congenital birth defects
☐ Anemia	☐ Tonsil/adenoid	☐ Blood dyscrasias	☐ Snoring
☐ Frequent Infections	☐ Tuberculous	☐ Cerebral palsy	☐ Seasonal Allergies
☐ Sickle cell disease/trait	☐ Cancer/tumors	☐ Autism	☐ Latex Allergies
☐ Diabetes	☐ Liver/GI disease	☐ Endocrine/growth	☐ Food Allergies
☐ Hepatitis	☐ Kidney Disease	☐ Spina bifida	☐ Recurrent headaches
☐ AIDS	☐ Rheumatic fever	☐ Shunts	☐ Eyesight

Other: _____

What is the reason for your child's dental visit? _____
Yes○ No○ Has your child ever been to the dentist?
Date of last cleaning & x-rays (if taken) _____
Yes○ No○ Has your child experienced any unfavorable reaction from previous dental care?
Yes○ No○ Has your child had a local anesthetic?
Yes○ No○ Has your child been sedated for dental treatment?
Yes○ No○ Have your child's teeth ever been injured?
Yes○ No○ Has your child had any treatment for dental trauma?
Yes○ No○ Does your child suck a finger, thumb or pacifier?
Yes○ No○ Does your child go to bed with a bottle or sippy cup?

Please circle if your child is having problems with any of the following:

Cavities☐ Toothache☐ Sensitive teeth☐ Mouth Breathing☐ Trauma☐ Gum Infections☐
Color of Teeth☐ Orthodontics☐ Jaw Sounds☐ Grinding of Teeth☐ Other☐

Yes○ No○ Is your home water supply fluoridated?
Yes○ No○ Does your child use a fluoride toothpaste?
Yes○ No○ Do you give your child any other forms of fluoride? If yes what?
Yes○ No○ Does your child participate in a school fluoride rinse program?

Consent For Dental treatment: I am the parent or legal guardian and the information listed on this form is complete and accurate. I give consent for Dr. Ortega and staff to perform a dental examination, dental prophylaxis, fluoride treatment and take x-rays on my child. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Jennifer Ortega DMD, PA of any changes in my child's medical status.

Parent/legal guardian's signature: _____ Date: _____