Bethel Kids DENTAL

531 W. Kettleman Lane
Lodi, CA 95240
Tel: 209-400-2018

1660 W. Yosemite Ave. #1
Manteca, CA 95337
Tel: 209-500-1910

3633 Bradshaw Rd. #A
Sacramento, CA 95827
Tel: 916-810-2025

RETURNING PATIENT FORM

Patient Name (First and Last Name): _____ DOB: _____

Phone: _____ 2nd Phone: _____Email: _____

Any changes to home address? If yes, please list new address below:

_____

Do you have a new dental insurance? If yes, please list Name and ID # below:

_____

Please check any dental concerns:

◯ Cavities ◯ Color of Teeth ◯ Grinding of Teeth ◯ Gum Infections ◯ Jaw Sounds
◯ Mouth Breathing ◯ Orthodontics ◯ Sensitive Teeth ◯ Toothache ◯ Trauma
◯ Dental Pain ◯ None ◯ Other: _____

Medical and Dental History

◯Yes ◯No When was your child's last dental visit? Date of last cleaning & x-rays (if taken) _____
◯Yes ◯No Has your child experienced any unfavorable reaction from previous dental care? If yes, please explain:
_____
◯Yes ◯No Does your child suck a finger, thumb, or pacifier (please circle)? If yes, when? _____
◯Yes ◯No Does your child go to bed with a bottle or sippy cup? If yes, what is in it? _____
◯Yes ◯No Does your child snack frequently? What are their favorite snack foods? _____
◯Yes ◯No Has your child had local anesthetic? If yes, were there any problems? _____
◯Yes ◯No Has your child ever been sedated for dental treatment? If yes were there any problems? _____
◯Yes ◯No Have your child's teeth ever been injured? Which teeth: _____
◯Yes ◯No Does your child have a cold sore or other mouth ulcer? Please describe:_____
◯Yes ◯No Does your child use a fluoride toothpaste?
◯Yes ◯No Does your child begin to smoke cigarettes or use any tobacco products?
◯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 Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain:
_____
◯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 Have you ever been told that your child needs to take antibiotics before dental treatment?

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

◯Abuse ◯Cancers/Tumors ◯Heart Murmurs ◯Sickle Cell Disease
◯ADHD ◯Cerebral Palsy ◯Hepatitis ◯Significant Injuries
◯Adverse Drug Reaction ◯Congenital Birth Defect ◯HIV/AIDS ◯Snoring
◯Anemia ◯Diabetes ◯Liver/GI Disease ◯Speech/Hearing Issues
◯Asthma/Breathing Problems ◯Endocrine/Growth Problems ◯Mental Delays ◯Spina Bifida
◯Autism ◯Eyesight Problems ◯Personality Problems ◯Tonsil Problems
◯Blood Transfusion ◯Frequent Infections ◯Recurrent Headaches ◯Tuberculosis
◯Blood Disorders ◯Heart Disease ◯Seizures ◯Other _____

Does your child have any allergies?

◯Medication(s) ◯Latex ◯Anesthetics ◯Bisphosphonate ◯Food
Please specify: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

Parent/Guardian Name & Signature: _____ **Date:** _____