HOUSTON PEDIATRIC DENTAL SPECIALISTS
11455 Fallbrook Dr., #202
Houston, Texas 77065

Regina L. Lewis, D.D.S.
Julie M. Longoria, D.D.S.

MEDICAL HISTORY

Child's Name / Nombre del Niño(a) _____ Nickname / Apodo _____

Date of Birth / Fecha De Nacimiento _____ Weight / Peso _____ Last physical examination / Ultima examinacion fisica _____ Last immunizations / Vacunàs _____ Pregnant? Y / N / Embarazada

Primary Care Provider / Provedor de cuidado primario _____ Phone / Telefono _____

Specialist / Especialista _____ Phone / Telefono _____

Specialist / Especialista _____ Phone / Telefono _____

1 **Does your child have any major health problems?** Y / N If yes, explain/explique _____
Tiene su hijo(a) algun problema mayor de salud?

2. **What medications is your child currently taking? What For?** _____
Que medicamentos esta tomando su hijo(a) actualmente?

3. **Was your child born premature?** Y / N If yes, explain/Explique _____
Es su hijo(a) un niño prematuro?

Week gestation?/Semanas de gestación _____ Birth weight/Cuanto Peso? _____

Was a feeding tube used?/Usaron un tubo de alimentación? _____ How long?/Por cuanto tiempo? _____

Was a breathing tube used?/Usaron tubo de respiración? _____ How long?/Por cuanto tiempo? _____

4. **Has your child been hospitalized?** Y / N If yes, explain/Explique _____
Ha sido su hijo hospitalizado alguna vez?

5. **Has your child ever had surgery?** Y / N If yes, explain/Explique _____
Ha tenido su hijo(al alguna cirugia?

6. **Does your child have a heart murmur or heart defect?** Y / N If yes explain/Explique _____
Tiene su hijo (a) algun soplo o defecto del corazón?

Was murmur present at birth?/Fue diagnosticado con un soplo en el corazón al nacer? _____

Type of murmur/Tipo de soplo? _____

Does your child have a heart card? _____

Has child been seen by a cardiologist?/Ha sido visto por un cardiologo? _____ When?/Cuando _____

When is the next cardiology appointment?/Fecha de la proxima cita cardiologa? _____

Does child require antibiotics for heart?/Requiere su hijo(a) antibiotico para el corazón _____

Heart surgery/Cirugia en el corazon _____

7. **Is your child currently being treated by a physician? Y / N If yes, explain/Explique** _____
Esta siendo tratado el paciente por un medico?

8. **Does your child suffer from any allergies? Y / N If yes, explain/Explique** _____
Sufre su hijo(a) de alerglas?

9. Has your child ever experienced an unfavorable reaction?
Ha experimentado el paciente alguna reaccion desfavorable a alguno de lo sigulente?

Drugs/Drogas | Antibiotics/Antiobioticos | Foods/Cornidas

Lactose intolerant/Intolerante a la lactosa | Local Anesthetics/Anestesia local | Dyes/Tintes

Metals/Metal | Acrylic/Acrilicos | Latex

Other _____

Rash?/Irritación?_____Treatment?/Tratamiento?_____Hives?/Ronchas?_____Treatment/Tratamiento? _____

Anaphylaxis?/Reaccion Anafilactica?_____Treatment/Tratamiento? _____

10. Does your child have asthma? Y / N If yes, explain/Explique_____
Sufre su hijo(a) de asma?

Last asthma attack/Fecha de ultimo ataque?_____

What causes an attack?/Que causa un ataque? _____

Has child ever been hospitalized for asthma?/Ha sido hospitalizado por asma? _____

Medications for asthma?/Medicamentos para el asma? _____

11. Does your child have diabetes? Y / N If yes, explain/Explique _____
Tiene su hijo(a) diabetes?

How long have they been an diabetic?/Cuanto tiempo tiene padeciendo diabetes? _____

Type I or II/Tipo 1 ó 2 Medication/Medicamentos _____

Frequency/Con que frecuencia lo toma? _____

12. Has your child ever undergone general anesthesia? Y / N If yes, explain/Explique _____
Ha estado su hijo(a) bajo anestesia general

13. Does you child have a history of developmental or behavior problems? Y / N If yes explain/Explique_____
Sufre el paciente de algun problema de desarroyo ó conducta?

Please circle/Porfavor circule: ADD, ADHD, OCD, ODD, Depression/Depresion, Autism/Autismo,

Other/Otro _____

14. Has or does your child have a history or difficulty with any of the following?
Tiene el paciente ó ha padecido alguna de las siguientes condiciones?

Please circle/Por favor circule las que apliquer

AIDS/Sida
Tuberculosis
Liver/Hepatitis/Higado
RSV
Rheumatic Fever/Fiebre Reumatica
Chronic Sinus/Sinusitis Cronica
Head Ache/Dolores de Cabeza
Snoring or Sleep Apnea/Ronca ó Apnea
Tonsils/Adenoids/Anginas/Amigdalas
Eczema/Eccema
Thyroid/Tiroides

High Blood Pressure/Presion Alta
Ulcers/Ulceras
Anemia
Bleeding Disorders/Problemas de Sangrado
Autism/Autismo
Down Syndrome
Cerebral Palsy/Paralisis Cerebral
Cleft lip/Cleft Palate/Labio Leporino ó Paladar
Cystic Fibrosis/Fibrosis Quistica
Bladder Infections/Infección de las vesicula
Kidneys/Riñon

Malignancies/Cancer/Cancer Maligno
Heart/Corazón
Seizures/Epilepsy/Epilepsia
Arthritis/Artitis
Speech Impairment/Problema del habia
Visual Impairment./Incapacidad visual
Ears/Hearing/Escuchar/Oidos
Smoking/Fuma
Obesity/Obesidad
Under Weight/Desnutricion
Eating Disorders/Desorden Allmenticio

Other/Otra _____

STAFF REVIEW/COMMENTS/COMMENTARIOS PARA EMPLEADOS: _____; _____

HYG **DR.**

DENTAL HISTORY/HISTORIA DENTAL

Last visit to the dentist: Date:_____ Dentist Name: _____
Ultima visita al Dentista: Fecha Nombre del Dentista

Services Rendered:_____ Were x-rays taken? _____
Servicios Rendidos Tomaron Radiografias?

BEHAVIOR:

A. **Does your child have dental complaints?** Y / N If yes, explain/Explique: _____
Tiene su hijo(a) algun problema dental?

_____

B. **Does your child have a swelling or infection in the mouth?** Y / N If yes, explain/Explique _____
Sufre su hijo(a) de alguna inchazón en la boca?

C. **What was your child's behavioral response to past dental care?** _____
Como ha sido el comportamiento de su niño(a) en el dentista?

D. **What is your child's attitude towards dentistry?** _____
Cual es la actitud de su hijo(a) hacia el dentista?

Are **YOU** anxious about the dentist? Y / N When was **YOUR** last checkup?_____ Do you have cavities? Y / N
Usted siente asnsiedad hacia el dentist? Cuando fue **SU** ultimo chequeo dental? **USTED** tiene caries?

E. **Does your child play sports? Please list/Cual:**_____ Does you Child wear a mouth guard Y / N
Juega su hijo(a) algun deporte? Utiliza su hijo(a) un protector oral?

F. **Does your child play a muscial instrument?** Y / N if yes, What?/Cual? _____
Toca algun instrumento musical?

Injuries/Lastimaduras

G. **Any injuries to the teeth, mouth, TMJ, or head?** Y / N If yes, explain/Explique _____
Ha sufrido trauma en sus dientes, boca, quijada, o cabeza?

When did this injury happen?_____ Did you child receive emergency dental care? _____
Cuando paso el accidente? Recibio cuidado dental de emergencia?

Habits/Habitos

Has you child had any of the following?
Tiene su hijo(a) uno de los siguientes habitos, por favor circule los que apliquen:

Bruxism (Grinding)/Rechina los dientes
TMJ/Joint Problems/Problemas de coyunturas o quijada
Snoring/Ronca
Thumbsucking/Chupa el dedo
Lip Biting/Se muerde el labio
Pacifier/Usa chupon
Nail biting/Se muerde las uñas
Fingersucking/Chupa los dedos
Nursing/Toma pecho
Bottle/Usa biberon

CHILD'S FULL NAME ______________________________ AGE __________

CHILD'S HOME ADDRESS ______________________________

____

FATHER'S FULL NAME ______________________________

FATHER'S MAILING ADDRESS (if different from childs) ______________________________

____

MOTHER'S FULL NAME ______________________________

MOTHER'S MAILING ADDRESS (if different from childs) ______________________________

____

FATHER'S SS # ______________________________ DATE OF BIRTH ______________________________

MOTHER'S SS # ______________________________ DATE OF BIRTH ______________________________

HOME PH # ______________ FATHER'S WORK # ______________ MOTHER'S WORK # ______________

FATHER'S EMPLOYMENT ______________________________

EMAIL ADDRESS ______________________________

MOTHER'S EMPLOYMENT ______________________________

EMAIL ADDRESS ______________________________

★★

NAME OF DENTAL INSURANCE CARRIER ______________________________

GROUP # ______________________________

★★

★★

We are happy to accept your insurance benefits for payment. We will estimate your portion to the best of our abilities. We require that you pay the estimated amount of the services that are performed. Any other remainders, after the insurance has paid their part, are due no later than 30 days after the insurance payment has been received. Any claims not paid within 60 days will be your **RESPONSIBILITY**.

Should patient be paid in error by your insurance co., contact Houston Pediatric Dental Specialists for further instruction immediately.

I hereby authorize payment directly to Dr. Lewis and Dr. Longoria of the Group Ins. Benefits otherwise payable to me.

SIGNED ______________________________ DATE ______________

Because your child is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any and or all necessary dental service can be started and accomplished.

The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental service and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, I will be responsible for any bill incurred on this child for dental treatment.

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. We would appreciate very much your acknowledging your receipt of our policy by signing this form.

Signed ______________________________

Parent or guardian

Date ______________________________