Natalie A. Lenser DDS

Pediatric Dentistry
3109 Coffee Road, Ste B, Modesto CA 95355

Patient Name _____ Age_____ Birthday_____

Home Address_____
Street City Zip Home Phone

Medical/Dental Update

Childs Physician_____

Physician Phone_____

Pharmacy_____

Is your child taking Fluoride Supplements Yes No

Any injuries to mouth, teeth, or head Yes No

For Office Use Only:

Pt. Wt_____

Date_____

Int._____

P: UR LR UL LL

Medical History

Reason for today's visit_____

Is your child under the care of a physician now? Yes No _____

Is your child taking Medication Daily? If Yes please list. Yes No _____

Does your child have any drug allergies? Yes No _____

Does your child have special needs? If yes please list. Yes No _____

Has your child ever been hospitalized? Yes No _____

Has your child ever had surgery? If yes please list. Yes No_____

Has your child ever had any of the following: (please circle all)

Yes	No	ADD/ADHD	Yes	No	Diabetes	Yes	No	Kidney Disease	Yes	No	Premature Birth
Yes	No	A.I.D.S/HIV	Yes	No	Drug/Alcohol Abuse	Yes	No	Liver Disease	Yes	No	Seasonal Allergies
Yes	No	Asthma	Yes	No	Epilepsy/Seizures	Yes	No	Measles/Mumps	Yes	No	Lung Problems
Yes	No	Autism	Yes	No	Fainting	Yes	No	Mononucleosis	Yes	No	Blood Disease
Yes	No	Anemia	Yes	No	Hearing Problems	Yes	No	Sinus Problems			
Yes	No	Bladder Problems	Yes	No	Heart Problems/Murmur	Yes	No	Rheumatic/Scarlet Fever	Yes	No	**Latex Allergy**
Yes	No	Cerebral Palsy	Yes	No	Congenital Heart Defect	Yes	No	Thyroid Disease	Yes	No	**Excessive Bleeding**
Yes	No	Chicken Pox	Yes	No	Hepatitis	Yes	No	Tuberculosis			
Yes	No	Hemophilia	Yes	No	Convulsions	Yes	No	Frequent Headaches			
Yes	No	Hives/Rash	Yes	No	Pain in Jaw Joints	Yes	No	Tonsillitis			
Yes	No	Cancer	Yes	No	Cold Sores/Fever Blisters						

Dr. Lenser's Comments_____

_____Dr. Sig_____

Authorization for Release

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payer and/or health practitioners.

_____ _____
Signature of Parent/Legal Guardian Date