

**Natalie A. Lenser DDS  
Pediatric Specialist  
3109 Coffee Road, Ste B, Modesto CA 95355**

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_\_\_

Home Address \_\_\_\_\_  
Street
City
Zip
Home Phone

**Medical/Dental Update**

Child's 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 \_\_\_\_\_

Has your child ever taken medications containing Bisphosphonates? (bone strengthener) Yes      No \_\_\_\_\_

**Does your child have any drug/food allergies? If yes please list**      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 <b>Latex Allergy</b>     |
| Yes    No    Bladder Problems | Yes    No    Heart Problems/Murmur     | Yes    No    Rheumatic/Scarlet Fever | Yes    No    Excessive Bleeding    |
| Yes    No    Cerebral Palsy   | Yes    No    Congenital Heart Defect   | Yes    No    Thyroid Disease         | Yes    No    Snoring when sleeping |
| Yes    No    Chicken Pox      | Yes    No    Hepatitis                 | Yes    No    Tuberculosis            | Yes    No    Sleep Apnea           |
| Yes    No    Hemophilia       | Yes    No    Convulsions               | Yes    No    Frequent Headaches      | Yes    No    Metal Allergy         |
| Yes    No    Hives/Rash       | Yes    No    Pain in Jaw Joints        | Yes    No    Tonsillitis             | Yes    No    Grinding              |
| Yes    No    Cancer           | Yes    No    Cold Sores/Fever Blisters | Yes    No    Bed Wetting             |                                    |

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