Katalina Ramirez D.D.S, M.S
Specialist in Pediatric Dentistry
358 Marine Parkway Suite # 300A
Redwood Shores, CA 94065

CHILD'S REGISTRATION AND HISTORY

Child's Name_____ Age _____
First Middle Last

Date of Birth_____ ☐ Male ☐ Female

Child's Interests _____ Nickname _____ Pets_____

Other children in family who have been or are patients in this practice (names and ages)

_____

_____

Who may we thank for referring you? _____

Father's Name _____ Father's birthday _____
Home address _____ City _____ Zip code _____
Home phone _____ Social security number _____
Business address _____ Business phone _____ Cell _____
Occupation _____ Employed by _____
Marital Status_____ Email _____

Mother's Name _____ Mother's birthday _____
Home address _____ City _____ Zip code _____
Home phone _____ Social security number _____
Business address _____ Business phone _____ Cell _____
Occupation _____ Employed by _____
Marital Status _____ Email _____

In case of emergency who should be notified _____

Party responsible for this account _____

DENTAL INSURANCE

Prime carrier _____ Employee name _____
Secondary carrier _____ Employee name _____

I authorize this office to affix my name to insurance claims and to release information to insurance companies.

Signed: _____ Date: _____

PLEASE COMPLETE OTHER SIDE →

HEALTH HISTORY

Child's physician _____ Address _____ Phone _____
Approximate date of last visit _____
Reason for visit _____

	YES	NO
Is child receiving any medication or drugs?	☐	☐
Name _____ Reasons _____		
Does child bleed excessively when cut?	☐	☐
If yes, explain _____		
Has child ever been hospitalized?	☐	☐
Explain _____		
Is there an allergy to penicillin or other drugs?	☐	☐
Name of drug _____		
Other allergies _____		
Does child have any behavior or emotional problems?	☐	☐
Explain _____		
_____		
Does your child have any handicaps or learning disabilities?	☐	☐
Explain _____		
Has your child been to a dentist before?	☐	☐
How long ago? _____ Were dental radiographs (x-rays) taken?	☐	☐
Is child taking any forms of fluoride?	☐	☐
What kind? _____		
How often does your child brush and floss teeth? _____		
Does your child receive help brushing and flossing? _____	☐	☐
Is your child using a nursing bottle? _____	☐	☐
Does your child have any habits such as thumb sucking, pacifier, etc.? _____	☐	☐
Please describe _____		
Does your child have any speech problems, nail biting, noisy eating, snoring, teeth grinding, difficulty swallowing? Please note: _____	☐	☐
Have you or your spouse had any serious dental problems? _____	☐	☐
_____		

Has you child been diagnosed as having any of the following?

____ Anemia	_____ H.I.V Positive	_____ Fainting	_____ Liver Disease	_____ Rheumatic fever
____ Asthma	_____ Sinus infection	_____ Hearing problems	_____ Malignancies	_____ Blood disease
____ Birth defects	_____ Convulsions	_____ Heart disease	_____ Measles	_____ Thyroid
____ Bladder disease	_____ Diabetes	_____ Blood transfusion	_____ Mononucleosis	_____ Tuberculosis
____ Cerebral palsy	_____ Epilepsy	_____ Kidney disease	_____ Heart murmur	_____ Hepatitis in family

Are there any other facts about your child you feel we should know or you would like us to consider? ☐ ☐
_____
_____

I authorize and request the performance of dental services upon the person of the above named patient as directed by the demands of his/her dental condition at the moment of performance of such service in accordance with the judgment of Katalina Ramirez DDS, MS.
I also authorize and request the administration of such anesthetics or sedatives as may be deemed advisable by Katalina Ramirez DDS, MS. NOTE: Any premedication/sedation will be discussed with the parent prior to the treatment.

Signed: _____ Date: _____
Parent or Guardian