EFRAIN S. RUIZ D.M.D., M. Sc. D.
PEDIATRIC DENTISTRY AND ORTHODONTICS

Patient's Name ______________________________ Nickname ____________________ Date __________
Last First

Age ___ Date of Birth ________ Sex ___ Race ________ School ____________________ Grade ________

Parents or Responsible Guardian ____________________ Telephone ______________________
Home Work

Address ____
Number and Street City State Zip

Brothers ________________ Sisters ________________ Pets ________________

Name of Child's Physician ______________________________ Date Last Seen ____________

Pharmacy ______________________________ Telephone ____________________

Reason for bringing child to the dentist ______________________________

Referred by ______________________________

HISTORY

		Yes	No	Reviewer Comments
1.	Is your child being treated by a physician at this time?	❑	❑	
	If yes, why? ____________________			
2.	Has your child ever been a patient in a hospital?	❑	❑	
	If yes, why? ____________________			
3.	Has your child ever received general anesthesia or sedation?	❑	❑	
	If yes, when? ____________________			
4.	Is your child allergic to anything? (medicine, food)	❑	❑	
	If yes, what? ____________________			
5.	Is your child taking any medicines at this time?	❑	❑	
	If yes, what? ____________________			
6.	Has your child ever had a blood transfusion?	❑	❑	
7.	Does your child smoke or use tobacco products?	❑	❑	
8	Has your child ever been seen by a dentist before?	❑	❑	
	Date last seen ______ Name of dentist ____________			
9.	Has your child ever received fluoride in any form?	❑	❑	
	If yes, what? ____________________			
10.	Does your child suck his/her thumb or fingers?	❑	❑	
11.	Are your child's teeth brushed once or more a day?	❑	❑	
12.	What type of toothpaste does your child use? ____________			
13.	At what age did your child stop bottle/breast feeding? ____________			
14.	Has your child ever had dental radiographs (X-Rays) made?	❑	❑	
	If yes, when? ____________________			

Organs and Systems

Has this child ever had any treatment for any of the following? Please check yes or no:

Yes	No		Yes	No		Yes	No	
❑	❑	Blood - Circulatory	❑	❑	Gastro intestinal - stomach	❑	❑	Muscles
❑	❑	Bones	❑	❑	Kidney - Bladder	❑	❑	Nervous System
❑	❑	Endocrine Glands	❑	❑	Heart	❑	❑	Skin
❑	❑	Eyes, Ears, Nose, Throat	❑	❑	Liver	❑	❑	Tonsils/Adenoids
❑	❑	Respiratory - Lungs						

❑ This child has **NOT** had any treatment for the above.

Illness

Has this child ever been diagnosed as having any of the following conditions? Please check yes or no:

Yes	No		Yes	No		Yes	No	
❑	❑	AIDS (Immunosuppresive Disorder)	❑	❑	Eye Problems	❑	❑	Pregnant
			❑	❑	Excessive Bleeding Problem	❑	❑	Psychiatric Disorder
❑	❑	Anemia	❑	❑	Fainting	❑	❑	Rheumatic Fever
❑	❑	Allergy	❑	❑	Hearing Loss	❑	❑	Scarlet Fever
❑	❑	Arthritis	❑	❑	Heart Disease	❑	❑	Scoliosis
❑	❑	Asthma	❑	❑	Heart Murmur	❑	❑	Sickle Cell Anemia
❑	❑	Autism	❑	❑	Hemophilia	❑	❑	Sinus Problems
❑	❑	Brain Injury	❑	❑	Hepatitis - Type ________	❑	❑	Snoring at Night
❑	❑	Bronchitis	❑	❑	Jaundice	❑	❑	Sore Throats - Frequent
❑	❑	Cancer	❑	❑	Leukemia	❑	❑	Spina Bifida
❑	❑	Cerebral Palsy	❑	❑	Measles	❑	❑	Syndrome ________
❑	❑	Chicken Pox	❑	❑	Mental Retardation	❑	❑	Tetanus
❑	❑	Cleft Lip/Palate	❑	❑	Mumps	❑	❑	Tuberculosis
❑	❑	Convulsions/Seizures	❑	❑	Mouth Breathing	❑	❑	Venereal Disease
❑	❑	Diabetes	❑	❑	Nutritional Deficiency	❑	❑	Whooping Cough
❑	❑	Diphtheria	❑	❑	Orthodpedic Problems	❑	❑	Other ________
❑	❑	Drug or Alcohol Abuse	❑	❑	Pneumonia			________
❑	❑	Epilepsy	❑	❑	Polio			________

❑ This child has never been diagnosed as having any of the above conditions.

Is there anything else that you think we should know about your child? ____________________

____

I certify that I have read and understand the above questions. I will not hold Dr. Efrain S. Ruiz or any member of his staff responsible for any errors or omissions I may have made in the completion of this form.

____________________ *Signature of person completing form*　　____________________ *Relationship to patient*　　__________ *Date*

Do NOT write below this line

Medical History Summary

Summarize from parent interviews or Medical Record. Include precautionary measures for Dental Care. ____________________

____

____

____

____

Prophylactic Antibiotic Recommendations____________________

____

____

Reviewer:____________________

PEDIATRIC DENTISTRY
CONSENT FOR DENTAL PROCEDURE AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

1. State Law requires us to obtain your consent to your child's contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it.
   I hereby authorize and direct **Dr. Efrain S. Ruiz** , assisted by other dentists and/or dental auxiliaries of his, to perform upon my child (or legal ward for whom I am empowered to consent) the following checked dental treatment or oral surgery procedure(s):
2. In general terms the dental treatment or procedure (s) will include:
   - ❑ A. Radiographs (x-rays) of the teeth and jaws.
   - ❑ B. Cleaning of the teeth and the application of topical fluoride.
   - ❑ C. Application of plastic "sealants" to the grooves of the teeth.
   - ❑ D. Use of local anesthesia to numb the teeth and tissues.
   - ❑ E. Treatment of diseased or injured teeth with dental restorations (fillings).
   - ❑ F. Replacement of missing teeth with dental prosthesis.
   - ❑ G. Removal (extraction) of one or more teeth.
   - ❑ H. Treatment of diseased or injured oral tissues (hard and/or soft).
   - ❑ I. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
   - ❑ J. Use of physical restraint or restraining devices to safely accomplish the necessary dental procedures.
   - ❑ K. Use of sedative drugs to control apprehension and/or disruptive behavior.
   - ❑ L. Use of General Anesthesia to accomplish the necessary treatment.
   - ❑ M. Other: ____________________

   The nature of my child's dental/orthodontic condition, the nature and purpose of the proposed treatment and procedures, and the possible risks and expected benefits of such treatment have been explained to me by **Dr. Efrain S. Ruiz.** Alternate procedures or methods of treatment, if any, have also been explained to me, as have their advantages and disadvantages, the risks, consequences and probable effectiveness of each, as well as the prognosis if no treatment is provided.
   I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to cure. I further authorize the doctor to perform other dental service(s) that in his judgement are advisable for my child or legal ward, with the exception of (if none so state): ____________________
3. I also authorize **Dr. Efrain S. Ruiz** to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications.
4. Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following the administration of topical flouride and children biting and injuring their tongue or lip following the administration of local anesthesia. Less common complications include the risks of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown form, an extracted tooth or gauze packing; injury to the tongue and/or lips, damage to and possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. For children with heart disease, the risk of subacute bacterial endocarditis (heart infection) following dental treatment exists, therefore antibiotics will be prescribed before and following treatment, to minimize the risk. I further understand and accept that complications may require additional medical, dental or surgical treatment and may require hospitalization.
   Additional risks include: ____________________
   I hereby state that I have read and understand this consent form, that I have been given an opportunity to ask questions I might have and that all questions about the procedure or procedures have been answered in a satisfactory manner; and I understand further that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.
   I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name ____________________

Signature of Parent or Guardian ____________________ Date __________ Time ______ am/pm

Relationship to Patient ______________ Witness ____________________

I certify that I explained the above procedures to the parent or legal guardian before requesting their signature.

____

RESPONSIBLE PARTY

MRS./MS./MISS/MR. ______________________________

SINGLE/DIVORCED/MARRIED/WIDOWED

RELATIONSHIP TO CHILD: MOTHER/FATHER/STEPMOTHER/STEPFATHER
GUARDIAN/OTHER ______________

ADDRESS: ______________________
____
PHONE ______________________

DOB ______________________
SSN ______________________
DRIVERS LIC# ______________

EMPLOYER: ______________________

NAME ______________________
ADDRESS ______________________
PHONE ____________ EXT ______

SPOUSE'S INFORMATION:

RELATIONSHIP TO CHILD: MOTHER/FATHER/STEPMOTHER/STEPFATHER
NAME: ______________________
GUARDIAN/OTHER ______________
ADDRESS: ______________________
____
PHONE ______________________

DOB ______________________
SSN ______________________
DRIVERS LIC# ______________

EMPLOYER: ______________________

NAME ______________________
ADDRESS ______________________
PHONE ____________ EXT ______

IF CHILD IS A FULL TIME STUDENT:
NAME OF SCHOOL ATTENDING ______________________

PERSON RESPONSIBLE FOR MAKING/CONFIRMING APPTS:
NAME ______________________
PHONE ______________________
BEST TIME TO CALL ______________________

IN CASE OF AN EMERGENCY CONTACT:
NAME ______________________
PHONE ______________________
RELATIONSHIP ______________________

FINANCIAL POLICY REVIEWED ______________

SIGNATURE OF POLICY HOLDER ______________________________
DATE ______________________

**YOUR SIGNATURE WILL ALLOW US TO FILL OUT & SEND COMPUTER GENERATED FORMS FOR YOU. WE WILL NEED TO KEEP ONE INSURANCE FORM ON FILE FOR OUR RECORDS.

Email Address

____

@ ______________________________