

**SHEILA HERNANDEZ, DMD PC  
PEDIATRIC DENTIST**

**Patient Information:**

Child's Complete Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Sex \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Place of Birth: \_\_\_\_\_ Language spoken at home \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ Hobbies: \_\_\_\_\_  
Sports: \_\_\_\_\_

Parents: Married \_\_\_ Divorced \_\_\_ Separated \_\_\_  
Who does the child lives with \_\_\_\_\_  
Relationship to the child \_\_\_\_\_  
Foster  
Parents \_\_\_\_\_

Please name Case worker, phone numbers where we can reach  
them \_\_\_\_\_

How long has child been under foster care \_\_\_\_\_

Is child adopted or in process of adoption? \_\_\_\_\_

**Family, Guardian, Foster Parent information:**

Father/ Step father complete name: \_\_\_\_\_ Date of  
Birth \_\_\_\_\_  
Place of Birth \_\_\_\_\_ Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Drivers License number  
\_\_\_\_\_  
Language spoken \_\_\_\_\_  
Address \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Telephone number \_\_\_\_\_ Mobile Number \_\_\_\_\_ Work Number  
\_\_\_\_\_ EXT. \_\_\_\_\_  
Employer \_\_\_\_\_ Work Address \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Contact Phone for Insurance \_\_\_\_\_

Mother/Step mother complete name: \_\_\_\_\_ Date of  
Birth \_\_\_\_\_  
Place of Birth \_\_\_\_\_ Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Drivers License number  
\_\_\_\_\_  
Language spoken \_\_\_\_\_  
Address \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Telephone number \_\_\_\_\_ Mobile Number \_\_\_\_\_ Work Number  
\_\_\_\_\_ EXT. \_\_\_\_\_  
Employer \_\_\_\_\_ Work Address \_\_\_\_\_  
Employer \_\_\_\_\_ Work Address \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Contact Phone for Insurance \_\_\_\_\_

Who is responsible for patients account?

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**Emergency contact person and number:**

Name of emergency contact \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Phone number of contact person: \_\_\_\_\_

Address: \_\_\_\_\_

**Medical History**

Child's Primary Physician \_\_\_\_\_ Telephone

Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Date Of Last Visit: \_\_\_\_\_ Purpose of Visit: \_\_\_\_\_

Are Child's vaccines up to date? yes \_\_\_ / No \_\_\_

If not to date why is it

so? \_\_\_\_\_

Describe your child's general health: Excellent \_\_\_ Good \_\_\_ On treatment \_\_\_\_\_

Select all the options that describe best your child's temperament or behavior:

Passive / Aggressive / Defiant / Amicable / Friendly / Cooperative / Shy / Outgoing

In your best judgment how do you describe your child's social development:

Normal / Advanced / Delayed

Is your child taking medication? Yes \_\_\_; No \_\_\_

If yes what are they prescribed

for? \_\_\_\_\_

Please list medications and dosages: \_\_\_\_\_

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Has your child had any reaction or allergies to any medication? Yes \_\_\_; No \_\_\_

Please

explain \_\_\_\_\_

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Has your child had any hospital stays? Yes \_\_\_; No \_\_\_

Please list and give

dates: \_\_\_\_\_

Has your child had any operations? Yes \_\_\_; No \_\_\_

Please list reason and

dates \_\_\_\_\_

Has your child had any traumatic injuries? Yes \_\_\_ : No \_\_\_

Please list type of injury and date:

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**Allergies to materials, food or environmental substances or particles**

Is your child allergic to Latex? Yes \_\_\_; No \_\_\_; Don't know \_\_\_\_\_

Is your child allergic to any kind of nuts and peanuts? Yes \_\_\_; No \_\_\_\_\_

Is your child allergic to seasonal pollen or molds? Yes \_\_\_\_\_ ; No \_\_\_\_\_  
Is there any kind of allergy your child suffers from and we have not included in the questionnaire? Yes \_\_\_\_\_ ; No \_\_\_\_\_  
If yes explain \_\_\_\_\_

Please circle any of the following medical problems if it's your Childs;

Asthma	Lung Problems	Heart Disease
Behavior Difficulties	Tuberculosis	Blood Dyscrasias
Learning Difficulties	Recurrent Infections	Transfusions
Food Allergies	Kidney Problems	Heart Murmur
Hay Fever	Liver Problems	Rheumatic Fever
Seasonal Allergies	Hepatitis	Prolonged Bleeding
Birth Defects	Jaundice	Hemophilia
Cleft Palate or Lip	Diabetes	Leukemia
Difficulty with Speech	Endocrine System Problems	Tumor
Difficulty with hearing	Epilepsy	Malignancy
Eye Disorders	Seizures	HIV/AIDS
Eye Infections	Recurrent Headaches	Mental Retardation
Throat infections	Problems with jaw Joints	Disabilities

Other: \_\_\_\_\_  
\_\_\_\_\_

**Dental History:**

Has your child been seen in another dental office? Yes \_\_\_\_\_ ; No \_\_\_\_\_  
Name of dentist \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Date of last dental exam: \_\_\_\_\_ Treatment provided: \_\_\_\_\_  
Date of last dental x-rays: \_\_\_\_\_  
Has your child experienced any unpleasant medical or dental treatment? Yes / No  
Explain: \_\_\_\_\_  
\_\_\_\_\_

Does your child have any cavities that you are aware of? Yes \_\_\_\_\_ ; No \_\_\_\_\_  
Is your child in pain today? Yes \_\_\_\_\_ ; No \_\_\_\_\_  
What is the nature of the pain? \_\_\_\_\_  
\_\_\_\_\_

Has your child had any trauma to the teeth or gums? Yes \_\_\_\_\_ ; No \_\_\_\_\_  
Explain: \_\_\_\_\_  
\_\_\_\_\_

Has your child any habits such as finger sucking, lip sucking or pacifier? Yes/No  
Does your child brush his teeth every day? Yes / No  
Do you assist in flossing and brushing? Yes / No  
Is your drinking water fluoridated? Yes / No  
Is your child receiving Fluoride supplements? Yes / No  
Is your child feeding by: Breast / Bottle  
When did your child stop feeding by breast or bottle? \_\_\_\_\_  
At what age were solid foods introduced? \_\_\_\_\_  
Do you like the way your child's teeth look? Yes / No

What do you want to change?

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Please explain in your own words what is the reason you seek our Pediatric Dentistry Services and the expectations you have from today's visit and further treatments.

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**Authorization for Treatment**

I authorize Dr. Sheila Hernandez, pediatric dentist of Sheila Hernandez, DMD PC and the dental staff to evaluate, take the necessary radiographs, pictures and study models if needed for treatment plan. I understand that an oral prophylaxis will be performed only if Dr. Hernandez understands that it is the appropriate treatment as part of my child's first visit.

I also understand that my insurance is an agreement between me and the insurance company. I also understand that all deductibles, co-payments and patients portion is due prior service is rendered.

I accept that I am responsible for any balance regardless of my insurance.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_