Houston Pediatric
Dental Specialists

Regina Lewis DDS and Julie M. Longoria DDS MSD
Diplomates American Board Of Pediatric Dentistry

Medical History

Child's Name_____Nickname_____
Nombre del Niño(a) Apodo

DOB_____Age:_____Weight_____Last physical examination_____
Fecha de Nacimiento Peso Ultima examinación

Last immunizations_____Pregnant? Y / N
Vacunás Embarazada

Primary Care Provider_____Phone_____
Provedor de cuidado primario

Specialist_____Phone_____
Especialista

Specialist_____Phone_____
Especialista

1. Does your child have any major health problems? Y / N If yes, explain/explique:
   Tiene su hijo(a) algun problema mayor de salud?

_____

_____

2. Is your child taking any medications? What for?_____
   Que medicamentos esta tomando su hijo(a) actualmente?

3. Was your child born premature? Y / N If yes, explain:_____
   Es su hijo(a) un niño prematuro?

   Weeks gestation / semanas gesatación?_____Birth weight / Cuanto peso?_____

   Feeding tube used / Usaron un tubo de alimentación? Y / N How long/Por cuanto tiempo?_____

   Breathing tube used / Usaron un tubo de respiración? Y / N How long/Por cuanto tiempo?_____

4. Has your child been hospitalized?_____
   Ha sido su hijo hospitalizado alguna vez

5. Has your child ever had surgery?_____
   Ha tenido su hijo(al alguna cirugia?

6. Does your child have a heart murmer or heart defect? Y/N If yes explain/Explique_____

   Has your child been seen by a cardiologist?/Ha sido visto por un cardiologo? Y / N
   When?/ Cuando?_____

   Does child require antibiotics?/Requiere su hijo(a) antibiotico ? Y / N

   Heart Surgery?/Cirugia en el corazon_____

7. Is your child currently being treated by a physician? Y/N If yes, explain/Explique
   Esta siendo tratado el paciente por un medico? _____

8. Does your child suffer from any allergies? Y/N If yes, explain/Explique
Sufre su hijo(a) de alerglas?_____

9. Has your child ever experienced an unfavorable reaction to any medicines, materials (ex. latex, acrylic), or foods?
Ha experimentado el paciente alguna reaccion desfaborable a alguno de lo sigulente?

If yes, please list:_____

Rash?/Irritacion? Y / N Hives?/Ronchas? Y / N Anaphylaxis?/Reaccion Anafilactica? Y / N

10. Does your child have asthma? Y / N
Sufre su hijo(a) de asma?

Last asthma attack?/Fecha de ultimo ataque?_____

What causes an attack?/Que causa un ataque?_____

Has child ever been hospitalized for asthma?/Ha sido hosptializado por asma?_____

Medications for asthma?/Medicamentos para el asma?_____

11. Does your child have diabetes? Y / N
Tiene su hijo(a) diabetes?

Type I or II/Tipo 1 or 2 Medication/Medicamentos_____

12. Has your child ever undergone general anesthesia? Y / N
Ha estado su hijo(a) bajo anestesia general?

If yes explain/ explique_____

13. Does your child have a history of developmental or behavior problems? If yes
Explain/ Explique_____

Please Circle/Porfavor circule: ADD, ADHD, OCD, ODD, Depression/Depresion,

Autism/Autismo, Other/Otro:_____

14. Has or does your child have a history or difficulty with any of the following?
Tiene el paciente o ha padecido alguna de las siguientes condiciones?

Please circle/Por favor circule las que apliques

Autism	Cancer	HIV/ AIDS	Seizures
Asthma	Chronic Sinusitis	High Blood Pressure	Thyroid
Anemia/Bleeding issues	Down Syndrome	Kidney/ Bladder	Tonsils/Adenoids
Cerebral Palsy	Eczema	Liver/ Hepapitis	Tuberculosis
Cleft lip/ palate	Eating Disorder	RSV	
Cystic Fibrosis	Heart	Speech/Visual Impairment	

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Dental History

Date of last dental visit:_____ Dentist Name:_____
Ultima visita al dentista Nombre del Dentista

Services rendered (please circle): Exam X-rays Cleaning Treatment
Por favor circule Examen Radiografias Limpieza Tratamiento

A. Does your child have dental complaints? Y / N If yes, explain:_____
Tiene su hijo(a) algun problema dental?

B. Does your child have a swelling or infection in the mouth? Y / N Where/donde?_____
Sufre su hijo(a) de alguna inchazón en la boca?

C. What was your child's behavioral response to past dental care?_____
Como ha sido el comportamiento de su niño(a) en el dentista?

D. What is your child's attitude toward dentistry/ dental care?_____
Cual es la actitud de su hijo(a) hacia el dentista?

Are you anxious about the dentist? Y / N
Usted siente asnsiedad hacia el dentist?

When was your last checkup? Y / N
Cuando fue su ultimo chequeo dental?

Do you have cavities: Y / N
Usted tiene caries

E. Any injuries to the teeth mouth, TMJ, head? Y / N If yes explain/explique:_____
Ha sufrido trauma en sus dientes, boca, quijada, o cabeza?

F. Has your child had issues with any of the following (past or present)?
Tiene su hijo(a) uno de los siguientes habitos, por favor circule?

Bruxism/Grinding/ Rechina los dientes	TMJ/ Problemas de coyunturas o quijada	Snoring/ Ronca
Thumbsucking/ Chupa el dedo	Lip Biting/ Se muerde el labio	Pacifier/ Usa chupon
Nail Biting/ Se muerde las uñas	Fingersucking/ Chupa los dedos	Nursing/ Toma pecho
Bottle/ Usa biberon		

G. What type of water does your child drink most often? Que tipo de agua toma?

Tap Water/ Faucet Refrigerator/Filtered Bottled Reverse Osmosis (hard water remover) Nursery Water Well Water

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PERSONAL INFORMATION

HOME ADDRESS:_____
House Number Street City State Zip Code

Father's Full Name:_____
Guardian
Address (If different from above):_____

Father's SS#_____-____-_____ DOB:_____ Email:_____

Employer:_____Work Number:_____

Employer Address:_____

Mother's Full Name:_____
Guardian
Address (If different from above):_____

Mother's SS#_____-____-_____ DOB:_____ Email:_____

Employer:_____Work Number:_____

Employer Address:_____

Insurance Information

Dental Insurance Carrier:_____Group No:_____

We are happy to accept your insurance benefits for payment. We will estimate your portion to the best of our abilities. We require that you pay the estimated amount on the day the services are rendered. Any other remainders, after the insurance has paid their part, are due no later than 30 days after the insurance payment has been received. Any claims not paid within 60 days will be YOUR RESPONSIBILITY.

Should the patient be paid in error by your insurance co., contact Dr. Julie Longoria or Dr. Regina Lewis for further instruction immediately.

I hereby authorize payment directly to Dr. Julie Longoria and Dr. Regina Lewis of the Group Ins. Benefits otherwise payable to me.

_____ _____
Signature Date

It is necessary that a signed permission is obtained from a parent or guardian before any and or all necessary dental service can be started and accomplished. The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental service and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, I will be responsible for any bill incurred on this child for dental treatment. We would appreciate acknowledgement of your receipt of our policy by signing below.

_____ _____
Signature Date