Teddy Bear Dental
Pediatric Dentistry
Dr. Ted I. Kim DDS
3500 Barranca Pkwy, Suite 260
Irvine, CA 92606

Tel: 949-786-1383
Fax: 949-786-1368

Patient's Name:____________________________

Birthdate:________________________________

Medical Doctor:______________________________

Doctor's Phone #:____________________________

Medical History

1.Date of last physical exam:________________________
2.Does your child have any health problems?.........Yes No
3.Has your child ever been hospitalized?...............Yes No
4.Is your child now under medical care?............... Yes No
5.Has he/she had a serious illness or surgery?....... Yes No
If yes, explain:__________________________________

Indicate which of the following your child has had or has been diagnosed. (Please circle Yes or No)

Rheumatic fever/rheumatic heart disease.......... Yes No
Heart murmur/congenital heart disease... .... Yes No
Cardiovascular disease (heart defects, heart attack, arteriosclerosis, high blood pressure, stroke)...... Yes No
Asthma or Hay fever..............................Yes No
Emphysema.......................................Yes No
Persistent cough or coughing blood...............Yes No
Tuberculosis.....................................Yes No
Hives or skin rash...............................Yes No
Arthritis/Inflammatory rheumatism (joints) .. ..Yes No
Fainting spells or seizures.......................Yes No
Epilepsy...Yes No
Cerebral Palsy...................................Yes No
Hepatitis, jaundice or liver disease.............Yes No
Diabetes...Yes No
Stomach problems, ulcers, etc.....................Yes No
Kidney problems..................................Yes No
Thyroid problems.................................Yes No
Sickle Cell Disease..............................Yes No
AIDS/HIV...Yes No
Venereal Disease.................................Yes No
Psychiatric treatment............................Yes No
Mental retardation...............................Yes No
Developmental disability.........................Yes No
Autism...Yes No
Attention Deficit Disorder (ADD/ADHD)...............Yes No
Vision/hearing/speech impairment..................Yes No
6.Was your child born premature?....................Yes No
7.Female adolescents: possibility of pregnancy? ...Yes No
8.Is your adolescent taking birth control?.............Yes No
9.Has he/she had surgery, radiation or chemotherapy for a tumor or growth?..............................Yes No

10.Has your child had abnormal bleeding with surgery, extractions, or accidents?..................... Yes No
11.Does he/she bruise easily?........................ Yes No
12.Has he/she had a blood transfusion?................Yes No
13.Does he/she have a blood disorder (anemia, etc)?.......Yes No
14.Is your child taking any of the following medications?
Antibiotics or sulfa drugs?...................... Yes No
Anticoagulants (blood thinner)?...................Yes No
High blood pressure medications?..................Yes No
Cortisone or steroids?............................Yes No
Tranquilizers?....................................Yes No
Aspirin?..Yes No
Dilantin or other anticonvulsant?................ Yes No
Insulin, tolbutamide/orinase?.................... Yes No
Other medications, please list:__________________________
____

15.Is your child allergic to or had an adverse reaction to:
Local anesthetics?............................... Yes No
Antibiotics (penicillin, sulfa, etc)?............... Yes No
Sedatives, Barbiturates?........................ Yes No
Aspirin?...Yes No
Other allergies? (medicine, foods, latex, etc.)?......... Yes No
If yes, list:__________________________________

Dental History

16.Date of last dental exam:________________________
17.How many times a day does your child brush?____________
18.How often does your child floss?______________________
19.Do his/her gums bleed when brushing?................ Yes No
20.Has he/she had gum disease?....................... Yes No
21.Does your child grind his/her teeth?................ Yes No
22.Does your child suck his/her thumb or fingers, bite his/her nails, or use a pacifier?.............. .... Yes No
23.Is your child currently on the bottle or breastfeeding?.....Yes No
24.Has he/she ever had injuries to the face or mouth?.........Yes No
25.Has your child been diagnosed with a cleft lip/plate?.......Yes No
26.Does your child have a disability that prevents treatment in the dental office?............................Yes No
27.Have you been dissatisfied with past dental treatment?...Yes No
If yes, explain:__________________________________
____

To the best of my knowledge, all of the above answers are true.
If my child has a change in health or medications, I will inform the dentist.
I authorize the dental staff to perform the necessary dental services my child may need.

________________________ ________________________ ____________
Signature of parent or guardian | Printed Name | Date

Reviewed by Dr.