

# John Ruzzamenti, DDS

41530 Enterprise Circle South ~ Suite 119 ~ Temecula, CA ~ 92590 (951) 296-3358

Please answer all questions on **both** sides, so we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

CHILD'S NAME: \_\_\_\_\_ Nickname \_\_\_\_\_  
 Male  Female Birthdate \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security No \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Father's Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
 Married  Single  Divorced  Seperated  Widowed

MOTHER'S NAME \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security No \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Mother's Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
 Married  Single  Divorced  Seperated  Widowed

With whom does the child reside? \_\_\_\_\_

### PAYMENT IS EXPECTED AT TIME OF EACH VISIT

PLEASE CHECK METHOD OF PAYMENT:

Cash  Check  Bankcard  Insurance

Primary Dental Insurance	Secondary Dental Insurance
Employee _____	Employee _____
Relationship To Patient _____	Relationship To Patient _____
Employer _____	Employer _____
Insurance Co _____ Group # _____	Insurance Co _____ Group # _____
Insured Birthdate _____	Insured Birthdate _____
Employee's S.S. No. _____	Employee's S.S. No. _____

Person responsible for child's account: \_\_\_\_\_ Phone No ( ) \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone No ( ) \_\_\_\_\_

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### IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Closest Relative \_\_\_\_\_ Phone No ( ) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Patient / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## DENTAL HISTORY

Is This your child's first dental visit?  Yes  No  
 Previous Dentist's Name? \_\_\_\_\_  
 date of last visit: \_\_\_\_\_  
 Does your child feel nervous about  
 having dental treatment?  Yes  No  
 Has your child ever had a bad dental experience?  Yes  No  
 Has your child been seen by an orthodontist?  Yes  No

Have there been any injury to your child's  
 teeth or jaw's? Falls? Blows? Chips? etc?  Yes  No  
 Has your child ever been premedicated w/antibiotics  
 for dental work?  Yes  No  
 Does your child receive fluoride  
 in vitamins, tablets, or water?  Yes  No

## HEALTH HISTORY

Is your child having any pain or  
 discomfort at this time?  Yes  No  
 Has your child been hospitalized during  
 the past 2 years?  Yes  No  
 Has your child been under the care of a medical  
 doctor during the past 2 years?  Yes  No  
 Physician Name \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

Is your child currently taking any medications?  Yes  No  
 Has your child taken any medicine / drugs  
 during the past 2 years?  Yes  No  
 If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_  
 Please list any serious medical condition(s) that your child  
 has or has had: \_\_\_\_\_  
 \_\_\_\_\_

Please Check  any of the following which your  
 child has now, or, has had in the past?

- |  |  |
|--|--|
| <input type="checkbox"/> Angina Pectoris                 | <input type="checkbox"/> Cosmetic Surgery                    |
| <input type="checkbox"/> Heart Disease / Attack / Stroke | <input type="checkbox"/> Emphysema / Asthma                  |
| <input type="checkbox"/> Heart Failure                   | <input type="checkbox"/> Cough / Tuberculosis (TB)           |
| <input type="checkbox"/> High / Low Blood Pressure       | <input type="checkbox"/> Arthritis / Rheumatism              |
| <input type="checkbox"/> Congenital Heart Defect         | <input type="checkbox"/> Cortisone Medicine                  |
| <input type="checkbox"/> Heart Murmur / Rheumatic Fever  | <input type="checkbox"/> Venereal Disease                    |
| <input type="checkbox"/> Heart Surgery                   | <input type="checkbox"/> A.I.D.S. / H.I.V.                   |
| <input type="checkbox"/> Heart Pacemaker                 | <input type="checkbox"/> Hepatitis: A (infectious) B (scrum) |
| <input type="checkbox"/> Artificial Heart Valve          | <input type="checkbox"/> Frequent Headaches                  |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Pain in Jaw Joint                   |
| <input type="checkbox"/> Blood Transfusion / Anemia      | <input type="checkbox"/> Artificial Joints (Hip, Knees)      |
| <input type="checkbox"/> Sickle Cell Disease             | <input type="checkbox"/> Scarlet Fever                       |
| <input type="checkbox"/> Bruise Easily                   | <input type="checkbox"/> Fever Blisters / Cold Sores         |
| <input type="checkbox"/> Hemophilia                      | <input type="checkbox"/> Fainting / Dizzy Spells             |
| <input type="checkbox"/> Liver Disease / Yellow Jaundice | <input type="checkbox"/> Epilepsy / Seizures / Convulsions   |
| <input type="checkbox"/> Kidney Failure / Dysfunction    | <input type="checkbox"/> Hay Fever / Sinus Trouble           |
| <input type="checkbox"/> Thyroid Disease / Parathyroid   | <input type="checkbox"/> Allergies / Hives / Rash            |
| <input type="checkbox"/> Ulcers / Stomach or Duodenal    | <input type="checkbox"/> Shingles                            |
| <input type="checkbox"/> Glaucoma                        | <input type="checkbox"/> Nervousness                         |
| <input type="checkbox"/> Chemotherapy / Cancer           | <input type="checkbox"/> Psychiatric Treatment               |
| <input type="checkbox"/> X-ray / Cobalt Treatment        | <input type="checkbox"/> Drug / Alcohol Addiction            |

Is your child allergic to, or had an adverse  
 reaction to any of the following?

*Please Circle*

- |  |   |
|--|---|
| • Aspirin                                | • Penicillin                                  |
| • Darvon                                 | • Erythromycin                                |
| • Codeine                                | • Tetracycline                                |
| • Demerol                                | • Other Antibiotics                           |
| • Percodan                               | • Latex                                       |
| • Valium                                 | • Metal / Jewelry                             |
| • Scopolamine                            | • Nitrous Oxide                               |
| • Sleeping Pills<br>(Nembutal / Seconal) | • Local Anesthetic<br>(Novocaine / Xylocaine) |

Are you aware of your child being allergic to any other  
 medications or substances? If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### Health History (for office use only)

Parent's Signature: \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Parent's Signature: \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Parent's Signature: \_\_\_\_\_ Today's Date \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Update Date \_\_\_\_\_  
 Parent's Signature: \_\_\_\_\_ Update Date \_\_\_\_\_  
 Parent's Signature: \_\_\_\_\_ Update Date \_\_\_\_\_