Natalie A. Lenser DDS
Pediatric Specialist
3109 Coffee Road, Ste B, Modesto CA 95355

Patient Name _____ Age_____ Birthday_____

Home Address_____
Street City Zip Home Phone

Medical/Dental Update

Childs Physician_____

Physician Phone_____

Pharmacy_____

Is your child taking Fluoride Supplements Yes No

Any injuries to mouth, teeth, or head Yes No

For Office Use Only:

Pt. Wt_____

Date_____

Int._____

P: UR LR UL LL

Medical History

Reason for today's visit_____

Is your child under the care of a physician now? Yes No _____

Is your child taking Medication Daily? If Yes please list. Yes No _____

Has your child ever taken medications containing Bisphosphonates? (bone strengthener) Yes No_____

Does your child have any drug/food allergies? If yes please list **Yes No** _____

Does your child have special needs? If yes please list. Yes No _____

Has your child ever been hospitalized? Yes No _____

Has your child ever had surgery? If yes please list. Yes No_____

Has your child ever had any of the following: (Please circle all)

Yes No ADD/ADHD	Yes No Diabetes	Yes No Kidney Disease	Yes No Premature Birth
Yes No A.I.D.S/HIV	Yes No Drug/Alcohol Abuse	Yes No Liver Disease	Yes No Seasonal Allergies
Yes No Asthma	Yes No Epilepsy/Seizures	Yes No Measles/Mumps	Yes No Lung Problems
Yes No Autism	Yes No Fainting	Yes No Mononucleosis	Yes No Blood Disease
Yes No Anemia	Yes No Hearing Problems	Yes No Sinus Problems	Yes No **Latex Allergy**
Yes No Bladder Problems	Yes No Heart Problems/Murmur	Yes No Rheumatic/Scarlet Fever	Yes No Excessive Bleeding
Yes No Cerebral Palsy	Yes No Congenital Heart Defect	Yes No Thyroid Disease	Yes No Snoring when sleeping
Yes No Chicken Pox	Yes No Hepatitis	Yes No Tuberculosis	Yes No Sleep Apnea
Yes No Hemophilia	Yes No Convulsions	Yes No Frequent Headaches	Yes No Metal Allergy
Yes No Hives/Rash	Yes No Pain in Jaw Joints	Yes No Tonsillitis	Yes No Grinding
Yes No Cancer	Yes No Cold Sores/Fever Blisters	Yes No Bed Wetting	

Dr. Lenser's Comments_____ Dr Sig_____

Authorization for Release

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payer and/or health practitioners.

_____ _____
Signature of Parent/Legal Guardian Date