



MELBA Z. MAYES, D.D.S., M.S.  
 PEDIATRIC DENTISTRY  
 2140 GRAND AVENUE, SUITE 200 • CHINO HILLS, CALIFORNIA 91709  
 (909) 548-4044 • (909) 548-0848 FACSIMILE

Dr. Mayes and her staff are pleased to welcome you and your child to our practice. Please take a few minutes to fill out these forms as completely as you can. If you have questions, we will be glad to help you. We look forward to working with you in maintaining your child's dental health!

**TELLS US ABOUT YOUR CHILD**

Child's Name:		Nickname:
Sex: Female / Male	Child's age:	DOB:
Child's Home Address:		School:
Phone:		Grade:
Child's Hobbies/Pets:		
Name & Age of Child's Siblings:		

**DENTAL HISTORY**

Is this your child's first visit to the dentist?	Yes	No
If no, give date of last dental visit:		
Were x-rays taken?	Yes	No
If yes, give date of last dental x-rays:		
Was your child cooperative at the last dental visit?	Yes	No
Has your child ever had an unfavorable dental experience?	Yes	No
Who may we thank for referring you?		
What is the name of your family dentist?		

**Please indicate if your child has had any of the following:**

Bad breath	Yes	No	Bleeding gums	Yes	No
Grinding teeth	Yes	No	Broken teeth	Yes	No
Tooth abscess/gum boil	Yes	No	Clenching teeth	Yes	No
Broken fillings	Yes	No	Gums swollen or tender	Yes	No
Mouth breathing	Yes	No	Sensitivity to chewing	Yes	No
Cold sores/ fever blisters	Yes	No	Finger or thumb sucking	Yes	No
Chew on one side	Yes	No	Blisters on lips or mouth	Yes	No
Fingernail biting	Yes	No	Loose teeth	Yes	No
Swelling or lumps in the mouth	Yes	No	Lip biting or sucking	Yes	No
Stained teeth	Yes	No	Orthodontic treatment	Yes	No
Tongue habit	Yes	No	Injury to teeth	Yes	No
Difficulty opening mouth	Yes	No	Chewing on objects	Yes	No
Toothaches	Yes	No	Clicking or popping of jaw	Yes	No
Pacifier habit	Yes	No	Sensitivity to cold	Yes	No
Jaw pain or tiredness	Yes	No	Burning sensation	Yes	No
Sensitivity to hot	Yes	No	Jaw sometimes lock	Yes	No
Dry mouth	Yes	No	Sensitivity to sweets	Yes	No
Injury to head, jaw, or chin	Yes	No	Does your child have, or did he or she ever have, a sucking habit beyond one year of age?	Yes	No

**Reason for today's visit:** (Circle all that apply)

Abscess/Infection      Bleeding gums      Dental Injury      Regular Exam      Toothache  
 Other: \_\_\_\_\_

Was your child nursed beyond one year of age? Nursing      Bottle      Both      Until what age? \_\_\_\_\_

**By what sources does your child receive fluoride?** (Circle all that apply)

Gel      Liquid Rinse      Pills      Toothpaste      Vitamins

Does your child brush daily?	Yes	No
How often?		
Does your child use dental floss?	Yes	No
How often?:		
Does an adult help your child daily with brushing the teeth?	Yes	No
Does an adult check nightly for thoroughness after brushing/flossing?	Yes	No

**MEDICAL HISTORY**

Child's Physician:		
Phone:		
Address:		
City:	State:	Zip:
Does your child have any health problems?	Yes	No
Has your child seen a physician in the past 12 months?	Yes	No
Has your child been hospitalized or been in the emergency room in the past 12 months?	Yes	No
Is your child under the care of a physician at this time?	Yes	No
Date and reason for last medical examination:		
Is your child taking any medications?	Yes	No
If yes, please list names of medications and dosages		
Were difficulties encountered during pregnancy or delivery of child?	Yes	No
If yes, please explain:		

**Does your child have any history of allergic reactions:** (Circle all that apply)

Environment (Dust, Pollen)    Food    Latex    Local Anesthetic    Medications (Amoxicillin, Penicillin, Sulfa)  
 Other: \_\_\_\_\_

<p><b>Blood and Immune System</b></p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Bleeding tendency</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No clotting disorder</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Anemia</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Sickle cell anemia or trait</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Blood transfusion</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Bruising problem</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Positive blood test for HIV</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Skin blotches or rashes</p> <p><b>Heart and Blood Vessels</b></p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Congenital Heart Disease</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Rheumatic Fever</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Heart Murmur</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Heart transplant/Valve problem</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Pacemaker</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Irregular heart beat</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No High Blood Pressure</p> <p><b>Respiratory</b></p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Breathing or lung problems</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Sinus problems</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Asthma</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Hay Fever</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Frequent nosebleeds</p>	<p><b>Bones and Muscles</b></p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Joint pain/arthritis/rheumatism</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Prosthetic or artificial joints</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Muscular dystrophy</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Physical disabilities</p> <p><b>Endocrine/GI System/GU System</b></p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Diabetes</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Family history of diabetes</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Thyroid/goiter or adrenal gland problem</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Dry Mouth</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Hepatitis</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Unexplained nausea or vomiting</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Intestinal or stomach problems</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Unexplained weight loss or gain</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Kidney problem</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Liver problem</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Frequency of urination/bladder disease</p> <p><b>Eyes and Ears</b></p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Eye problem</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Deafness/Hearing loss</p> <p><b>Oncology</b></p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Tumors/Cancer/Leukemia</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Chemotherapy/Radiation therapy</p>	<p><b>Nervous System</b></p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Attention Deficit Disorder</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Autism</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Brain injury</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Cerebral palsy</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Convulsion/seizures/epilepsy</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Dizziness/problems with balance</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Fainting spells/loss of consciousness</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Mental problems</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Neurological problems</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Paralysis/Polio</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Psychiatric disorder</p> <p><b>Genetic/Developmental</b></p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Birth defect</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Cleft lip</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Cleft palate</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Down's Syndrome</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Other Genetic disorder</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Other Syndrome</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Any other medical problem not mentioned</p> <p><b>Other</b></p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Car/motion sickness</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Concentration problems</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Cooperating problems</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Fear of strangers</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Speech problems</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Understanding problems</p>
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**MINOR/CHILD CONSENT**

I am the parent, guardian, or personal representative of \_\_\_\_\_  
 \_\_\_\_\_ (Please print the name of Minor/child) and there are no court orders now in effect that prohibit me from signing this consent. I understand that the personal/medical/dental information that I have given is complete and correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

Date: \_\_\_\_\_  
 \_\_\_\_\_  
 Signature of Parent, Guardian or Personal Representative

Date: \_\_\_\_\_  
 \_\_\_\_\_  
 Melba Z. Mayes, D.D.S., M.S.

**PARENT INFORMATION**

Mother's Name:		
Phone:		Cell Phone:
Address:		
City:	State:	Zip:
Marital Status	Birthday:	SSN:
Driver's License Number:		
Employer:		Occupation:
Business Address:		
City:	State:	Zip:
Business Phone:		E-Mail:

Father's Name:		
Phone:		Cell Phone:
Address:		
City:	State:	Zip:
Marital Status	Birthday:	SSN:
Driver's License Number:		
Employer:		Occupation:
Business Address:		
City:	State:	Zip:
Business Phone:		E-Mail:

Guardian's Name (if applicable):		
Phone:		Cell Phone:
Address:		
City:	State:	Zip:
Marital Status	Birthday:	SSN:
Driver's License Number:		
Employer:		Occupation:
Business Address:		
City:	State:	Zip:
Business Phone:		E-Mail:
Do you have legal custody of this child?		Yes      No

**EMERGENCY INFORMATION**

Name of Relative Not Living With You:		
Phone:		Cell Phone:
Address:		
City:	State:	Zip:

**INSURANCE INFORMATION**

Primary Dental Insurance Co. Name:		
Phone:	Group Number (Plan or Policy)	
Address:		
City:	State:	Zip:
Insured's Name:		SSN:

Secondary Dental Insurance Co. Name:		
Phone:	Group Number (Plan or Policy)	
Address:		
City:	State:	Zip:
Insured's Name:		SSN:

**INSURANCE ASSIGNMENT AND RELEASE**

I certify that my dependent is covered by insurance with \_\_\_\_\_  
\_\_\_\_\_(name of insurance company) and assign directly to Dr. Mayes all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Date: \_\_\_\_\_  
\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to child