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Acct. No. \_\_\_\_\_

**PATIENT REGISTRATION  
 HISTORY-CHILD**

**Name** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Middle Last

**Birth Date** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age** \_\_\_\_\_  Male  Female **School** \_\_\_\_\_ **Grade** \_\_\_\_\_

**Home Address** \_\_\_\_\_ **Home Phone** \_\_\_\_\_  
Street City State Zip

**Mother's Name** \_\_\_\_\_ **Employer** \_\_\_\_\_ **D.O.B** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Phone No.** \_\_\_\_\_ **Social Security No.** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **E-Mail** \_\_\_\_\_

**Insurance Company Name** \_\_\_\_\_ **ID No.** \_\_\_\_\_

**Father's Name** \_\_\_\_\_ **Employer** \_\_\_\_\_ **D.O.B** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Phone No.** \_\_\_\_\_ **Social Security No.** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **E-Mail** \_\_\_\_\_

**Insurance Company Name** \_\_\_\_\_ **ID No.** \_\_\_\_\_

Patient lives with  Both Parents  Mother  Father  Other \_\_\_\_\_

**Referred By?** \_\_\_\_\_

**MEDICATIONS CURRENTLY TAKING:** \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE CHECK YES OR NO TO THE FOLLOWING:**

| YES                      | NO  | YES                      | NO  |
|--------------------------|---|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Has patient had a physical exam in the past year?  | <input type="checkbox"/> | <input type="checkbox"/> Has patient had any reactions to any medications?        |
| <input type="checkbox"/> | <input type="checkbox"/> Is patient presently under a physician's care?     | <input type="checkbox"/> | <input type="checkbox"/> Has patient had his/her tonsils and/or adenoids removed? |
| <input type="checkbox"/> | <input type="checkbox"/> Has Patient ever been hospitalized?                | <input type="checkbox"/> | <input type="checkbox"/> Does patient experience fainting or dizzy spells?        |
| <input type="checkbox"/> | <input type="checkbox"/> Is patient taking any pills, medications or drugs? | <input type="checkbox"/> | <input type="checkbox"/> Does patient have too high or too low blood pressure?    |
| <input type="checkbox"/> | <input type="checkbox"/> Has patient ever had major surgery?                |                          |   |

**HAS PATIENT BEEN DIAGNOSES OR TREATED FOR:**

| Yes                      | No  | Yes                      | No                                    |
|--------------------------|---|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> Heart problems     | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis    |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> | <input type="checkbox"/> Diabetes     |
| <input type="checkbox"/> | <input type="checkbox"/> Lung problems      | <input type="checkbox"/> | <input type="checkbox"/> Malignancies |
| <input type="checkbox"/> | <input type="checkbox"/> Liver problems     | <input type="checkbox"/> | <input type="checkbox"/> Anemia       |
| <input type="checkbox"/> | <input type="checkbox"/> Endocrine problems | <input type="checkbox"/> | <input type="checkbox"/> Arthritis    |
| <input type="checkbox"/> | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> | <input type="checkbox"/> Bone         |
| <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> | <input type="checkbox"/> Asthma       |
| <input type="checkbox"/> | <input type="checkbox"/> Herpes             | <input type="checkbox"/> | <input type="checkbox"/> Aids         |

**PLEASE CHECK IF PATIENT IS ALLERGIC TO THE FOLLOWING:**

Aspirin  Codeine  Penicillin  Sulfa  Latex  Metals  
 Other \_\_\_\_\_

**Dr. Notes:**

**MEDICAL ALERT**  
 Yes No

Are there any other medical problems I should be aware of? \_\_\_\_\_  
 \_\_\_\_\_

**DENTAL HISTORY**

**DENTIST NAME** \_\_\_\_\_ **PHONE** \_\_\_\_\_ **DATE OF LAST CLEANING** \_\_\_\_/\_\_\_\_/\_\_\_\_

| Yes                      | No  | Yes                      | No   |
|--------------------------|---|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Has patient ever had orthodontic consultation or treatment?  | <input type="checkbox"/> | <input type="checkbox"/> Does patient grind or clench his/her teeth                    |
| <input type="checkbox"/> | <input type="checkbox"/> Has patient been informed of any missing teeth?              | <input type="checkbox"/> | <input type="checkbox"/> Does patient have pain or clicking of the jaw?                |
| <input type="checkbox"/> | <input type="checkbox"/> Have any permanent teeth been removed by extraction?         | <input type="checkbox"/> | <input type="checkbox"/> Has patient ever had any teeth injured by due to an accident? |
| <input type="checkbox"/> | <input type="checkbox"/> Has a family member had orthodontic treatment?<br>Who? _____ | <input type="checkbox"/> | <input type="checkbox"/> Has patient ever had pains in the face?                       |
| <input type="checkbox"/> | <input type="checkbox"/> Does patient breathe predominately through his/her mouth?    | <input type="checkbox"/> | <input type="checkbox"/> Has patient ever had severe jaw or head injury?               |
| <input type="checkbox"/> | <input type="checkbox"/> Does patient have any speech problems?                       |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Does patient now suck his/her thumb or finger?               | <input type="checkbox"/> | <input type="checkbox"/> Does patient's gums bleed when brushing or flossing?          |

Are there any other dental/orthodontic problems I should be aware of? \_\_\_\_\_

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