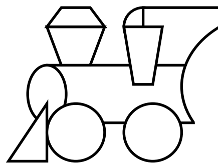

Terrence Y. Lau, DDS
121 N. San Mateo Drive
San Mateo, CA 94401
650-342-1512

## Patient Information and Health History

Child's name ________________________________________ Nickname ____________ Age______ Birthday___________
FIRST MI LAST
School _________________________________ Grade _______ Child's Place of Birth ____________________M___ F ___
Home Address_____________________________________ City___________________ State_______ Zip_____________
Home Phone _________________________ Names and age of other children_______________________________________
Child's interest _________________________________________________________________________________________

Has your Child been to another dentist before? Yes____ No____
Is this an Emergency visit? Yes____ No____ Explain_________________________________________________________
Name of previous dentist____________________________ City _____________________ When was last visit __________

Are there any concerns you have in regards to your child's teeth? ________________________________________________
Does your child have any of the following oral habits? Finger sucking_____ Pacifier_____ Thumb Sucking_____
Child's behavior: shy ____ fearful ____ normal ____

**Who may we thank for referring you?** ___________________________________________________________________

***Parent #1*** Name _________________________________________ DOB _______________

Business Phone_________________________________ Mobile Phone __________________________________________
Occupation ____________________________________ Name of Employer ____________________________

***Parent #2*** Name _________________________________________ DOB _______________
Business Phone _________________________________Mobile Phone __________________________________________
Occupation ____________________________________ Name of Employer ____________________________

Do parents live together? Yes____ No____

In case of emergency who should be notified ___________________________________________

## Primary Person Responsible for Account

Name _____________________________ Relationship ______________________ Marital Status _____________________
Social Security # __________________________Driver License #_____________________________
Employer Name__________________________________________________________________________________________
Employer Address _______________________________________________________________________________________
Is primary person covered by insurance? Yes____ No____
If Yes: Name of Insurance Company________________________________ Address _____________________________
Address _____________________________________ City ___________________ Sate ______ Zip ____________
Local # ________________________ Group# ____________________________ Policy and/or ID #__________________

## Is Patient covered by another insurance?

Name of insured__________________________ Relationship ___________________ Marital Status __________________
Social Security # __________________________Driver License #_____________________________
Employer Name__________________________________________________________________________________________
Employer Address _______________________________________________________________________________________
Name of Insurance Company________________________________ Address _______________________________
Address _____________________________________ City ___________________ State ______ Zip ____________
Local # ________________________ Group# ____________________________ Policy and/or ID #__________________

**Please complete other side**

# Health History

Name of Child's Physician ____________________________________________ Phone ____________________________
Address_____________________________________________________________________ Date of last visit__________________

Is your child in good health? Yes____ No____
Are your child's immunization up to date? Yes____ No____
Is your child taking any medications or drug? Yes____ No____
(If yes explain) ____________________________________________________
Has your child been hospitalized or had surgery? Yes____ No____
(If yes explain) ____________________________________________________
Does your child have any allergies or reaction to medication? Yes____ No____
(If yes explain) ____________________________________________________
Does your child have allergies to Latex? Yes____ No____
Does your child have allergies to Metals? Yes____ No____
Does your child have allergies to the following? Pollen____ Food____ Dyes____ Dust____ Other____

Has your child been diagnosed with any of the following conditions? Please check Yes or No:

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ____ | ____ | AIDS | ____ | ____ | Eye Problems |
| ____ | ____ | Allergies to Medication | ____ | ____ | Excessive Bleeding Problems |
| ____ | ____ | Anemia | ____ | ____ | Fainting or Dizziness |
| ____ | ____ | Asthma/Lung Problems | ____ | ____ | Growing & Development Problem |
| ____ | ____ | Autism | ____ | ____ | Heart Problems |
| ____ | ____ | Behavior/Learning Problems | ____ | ____ | Hearing/Speech Problems |
| ____ | ____ | Bladder Conditions | ____ | ____ | Hemophilia |
| ____ | ____ | Blood Transfusion | ____ | ____ | Hepatitis or Liver Disease |
| ____ | ____ | Birth Defects | ____ | ____ | Hyperactivity |
| ____ | ____ | Bone or Joint Problems | ____ | ____ | Kidney Disease |
| ____ | ____ | Brain Surgery | ____ | ____ | Leukemia |
| ____ | ____ | Cancer or Malignancies | ____ | ____ | Mental/Emotional Disturbance |
| ____ | ____ | Cerebral Palsy | ____ | ____ | Nutritional Deficiency |
| ____ | ____ | Chronic Adenoid/Tonsil Infections | ____ | ____ | Oral Ulcers |
| ____ | ____ | Chronic Ear Infections | ____ | ____ | Orthopedic Problems |
| ____ | ____ | Chronic Headaches | ____ | ____ | Premature Birth |
| ____ | ____ | Cleft Lip/Palate | ____ | ____ | Rheumatic Fever |
| ____ | ____ | Convulsions/Seizures | ____ | ____ | Significant Injury |
| ____ | ____ | Diabetes | ____ | ____ | Syndromes |
| ____ | ____ | Epilepsy | ____ | ____ | Other (Explain) ____________________ |

Is there any other information about your child you feel we should know or would like us to consider? No____ Yes____
Explain ______________________________________________________________________________

I authorize and request the performance of dental services upon the person of the above named patient as directed by the demands of his/her dental condition at the moment of performance of such service in accordance with the judgment of Terrence Y. Lau, DDS.

I also authorize and request that administration of such anesthetics or sedatives as may be deemed advisable by Terrence Y. Lau, DDS.

NOTE: Any premedication/sedation will be discussed with the parent prior to the treatment.

Signed____________________________________________ Date __________________
Parent or Guardian