



Today's Date: _____

Childs Name: _____ Preferred Name: _____
First MI Last

☐ Male ☐ Female Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____
Month Day Year

Home Phone: _____ Home E-mail _____ School _____

Home Address: _____
Street City State Zip

PARENTAL / GUARDIAN INFORMATION

Father's Name: _____ **Date of Birth:** ____ / ____ / ____
Month Day Year
Employed By: _____ **Social Security #:** ____ - ____ - ____
Work Phone: _____ **E-mail:** _____ **Cell Phone** _____

Mother's Name: _____ **Date of Birth:** ____ / ____ / ____
Month Day Year
Employed By: _____ **Social Security #:** ____ - ____ - ____
Work Phone: _____ **E-mail:** _____ **Cell Phone** _____

Person responsible to pay for this account: _____
Address if different from child's: _____

FOR INSURANCE VERIFICATION PURPOSES ONLY

Name of Subscriber: _____ Insurance ID#: _____ Group/Policy# _____
Name of Company (employer) insurance is through: _____
Name of Dental Insurance: _____ Phone: _____
Insurance Mailing Address: _____

JOSE LOZA, DDS | JUAN LOZA, DDS

DENTAL QUESTIONNAIRE

1. Date of last visit to the dentist? _____
2. What was done then? _____
3. Were x-rays taken? _____
4. Child's attitude towards dentistry _____
5. Has child complained about dental problems? _____ Yes No
6. Any injuries to mouth, teeth or head? _____ Yes No
7. Any mouth habits: Thumbsucking, nail biting, mouth breathing, nursing / bottle / pacifier, etc. _____ Yes No
8. Any unusual speech habits? _____ Yes No
9. Does child clench or grind teeth, awake or asleep? _____ Yes No
10. Do gums bleed easily? _____ Yes No
11. Does your child take floride in any form? _____ Yes No
12. Does your child brush daily? How Often? _____ Yes No

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.

Date _____ Signature of Patient _____

Signature of Dentist _____

Thank you for supplying us with the necessary information.

Or how did you hear about Loza Dental Great Falls?

☐ Advertising ☐ Web Site ☐ Other _____
Friend / Relative / Associate

JOSE LOZA, DDS | JUAN LOZA, DDS

HEALTH QUESTIONNAIRE

MEDICAL HISTORY

Circle Yes or No

1. _____ Name Address and Phone Number of child's physician: _____
2. _____ Date of child's last physical examination? _____ Results: _____
3. _____ Is the child receiving any medication or drugs? Yes
No
4. _____ Has the child had hip or joint surgery/replacement? Yes
No
- _____ Has child ever been hospitalized? Yes
No
5. _____ Is there any excessive bleeding when cut or injured? Yes
No
6. _____ Has the child had a history of congenital heart lesions, heart murmur or mitro valve prolapse? Yes No

7. _____ Does the Child need to be premedicated before dental treatment? Yes
No
8. _____ Which antibiotic?
Is there any allergy to penicillin, sulfa drugs, aspirin, local anesthetics, latex or other drugs? Yes No

9. _____ Is/are there any other allergy /allergies (food, pollen, animals, dust, or other)? Yes
No
10. Is the child HIV positive? _____ Yes No
- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mastoid |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Heart | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Kidney | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chronic Sinus | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Other |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Malignancies | |
11. Are there any emotional problems? _____ Yes No
12. Does the child have good physical coordination? _____ Yes No
13. Summary (For Doctor's Use) _____ Yes No
14. Has the child had any history of or difficulty with any of the following? If Yes Please Check

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.



DENTAL

HEALTH & WELLNESS

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Great Falls

Healthy Smiles



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CADENT
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Zoom!

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