

Medical History:

Has your child ever had any of the following medical Problems?

Y N Allergies	Y N Convulsion/Epilepsy	Y N Lung Problems
Y N Anemia	Y N Diabetes	Y N Mental Disorder
Y N Asthma	Y N Drug/Alcohol Abuse	Y N Nervous System Disorder
Y N Bleeding Disorder	Y N Fainting	Y N Rheumatic Fever
Y N Bronchitis	Y N Handicap/Disabilities	Y N Speech Disorder
Y N Cancer/Chemotherapy	Y N Hearing Impairment	Y N Tuberculosis
Y N Cerebral Palsy	Y N Hepatitis	Y N Tumors/Growths
Y N Congenital Heart Defect	Y N HIV/AIDS	Y N ADD/ADHD
Y N Heart Murmur	Y N OCD	Y N ODD
	Y N Autism	Y N Kidney Problems

Has your child experienced any other physical or mental disorder that is not listed above? Yes _____ No _____

If yes, please describe: _____

Parents, if yes to any above please explain _____

Doctor's Comments _____

Is your child allergic to any of the following drugs?

Y N Penicillin Y N Amoxicillin Y N Erythromycin Y N Codine Y N Dental Anesthetic

Is your child allergic to any other drugs? Yes _____ NO _____ If yes please list _____

Is your child allergic to latex, red dye, eggs, or anything we need to be aware of? Yes ___ No ___ If Yes please list _____

Is your child presently under the care of a physician for any illness? Yes ___ No ___ If Yes please explain _____

List any drugs or medicines presently being taken: _____

Has your child ever been hospitalized? Yes ___ No ___ If Yes, please give reasons and date(s) _____

Dental History:

Why did you bring your child to see us today? _____

Is this your child's first visit to the dentist? Yes ___ No ___

Has your child ever had a serious/difficult problem associated with previous dental work? Yes ___ No ___ If Yes, please explain _____

Date of last dental visit _____ Name of Dentist _____ For what service _____

Were any x-rays taken? Yes ___ No ___ If Yes, have x-rays been sent to our office? _____ Date requested _____

How do you expect your child to behave in our office? _____

Y N Does your child brush his/her teeth daily?

Y N Do you assist child with tooth brushing?

Y N Is dental floss used?

Y N Does your child take any type of fluoride supplement?

Y N Any mouth habits (thumb sucking, nail biting, mouth breather, nursing bottle habits, pacifier, etc.)

Y N Any injuries to mouth, teeth, head? Dates _____

May we request the release of your child's medical records? _____

Thank you for your help. If there is any information that you feel might be of value to us in the treatment of your child, please add it here: _____

I give my consent to needed dental treatment and the use of proper and acceptable methods to complete said treatment for my child, (child's full name) _____. I accept responsibility for payment of services rendered.

Signed (Parent or Guardian) _____ Date _____