Medical History

Child's Physician _____ Phone _____

Physician's Contact (Email or Tel) _____

Date of last visit _____ Has your child had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Is your child currently under physician care? ❑ Y ❑ N If yes, describe _____

Has your child ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Check (✓) yes or no whether your child has had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anemia
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chicken Pox
❑ Y ❑ N Convulsions/Epilepsy
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Headaches
❑ Y ❑ N Hearing Impairment
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Hemophilia/ Abnormal bleeding
❑ Y ❑ N Immunizations current
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Sinus problems
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Other
Describe _____

List medications your child is taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

Dental History

What would you like us to do for your child today? _____

_____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

How often does your child brush? _____ Floss? _____

Does your child experience pain or discomfort in the jaw joint? ❑ Y ❑ N

Has your child ever experienced a mouth or chin injury? ❑ Y ❑ N

Does your child have speech problems? ❑ Y ❑ N

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Child's habits affecting the mouth or teeth: ❑ Thumb sucking ❑ Nail biting ❑ Other _____

Other information about your child's dental health or previous treatment _____

_____

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.