Medical History

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

Is your child currently under the care of a physician? Y N
Child's Physician: _____
Physician's Phone #: _____

Is your child allergic to any drugs? Y N
If yes, please list: _____

Is your child taking any prescription drugs? Y N
If yes, please list: _____

Does your child need premedication before dental treatment? Y N

Has your child ever had any of the following medical conditions or problems?

Any hospital stays Y N
Operations Y N
Bleeding Problems of Any Kind Y N
Cancer Y N
Convulsions/Epilepsy Y N
Diabetes Y N
Hearing Impairment Y N
Heart Murmur Y N
Heart Problems of Any Kind Y N
Hemophilia Y N
HIV+/ AIDS Y N
Hyperactive Y N
Rheumatic/ Scarlet Fever Y N
Are there any medical conditions or problems relating to your child? Y N
If yes, please list: _____

Update
*Office Use Only

_____ __/__/____
initials date

_____ __/__/____
initials date

_____ __/__/____
initials date

_____ __/__/____
initials date

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____
Phone: _____ Phone #2: _____

*Please understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.
The parent or guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved

Signature: _____ **Date:** ____/____/_____