

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:

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

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.