

# 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/<br>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<br>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<br>( <b>latex</b> , wool, metal,<br>chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or<br>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     |   | <input type="checkbox"/> Y <input type="checkbox"/> N Other                             |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent      | Describe _____   |   | 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.**