Child's Medical History

Smile after beautiful smile since 1969.

Name: ____

Date of Birth: ______________________

Account #: _____________ Gender: _____________

The following questions are to help the Doctors understand your child's health better and to help us provide the best treatment possible, Thank You.

Who is your child's pediatrician? ______________________ *Phone #* __________________________

Has your child ever been hospitalized? Yes ◯ *No* ◯ *If yes, When and why?* __________________________

Is your child allergic to any of the following? Please Circle the appropriate answer.

Penicillin/Augmentin	Y	N	Sulfa Drugs	Y	N	Clindamycin	Y	N
Erythromycin	Y	N	Tetracycline	Y	N	Cephalosporins	Y	N
Dental Anesthetic	Y	N	Aspirin/Ibuprofen	Y	N	Latex	Y	N

List any drug or food allergies: ____

____

Is your child currently taking any medications? If so, please list: ______________________________

____

Has your child had any of the following? Please circle the appropriate answer.

Asthma	Y	N	Down's Syndrome	Y	N	Learning Disabilities	Y	N
Birth defects	Y	N	Epilepsy/Seizures	Y	N	Liver disease	Y	N
Blood/bleeding disorders	Y	N	Fainting spells	Y	N	Psychiatric problems	Y	N
Cancer	Y	N	Hearing loss/ impairment	Y	N	Sickle Cell Anemia	Y	N
Cerebral Palsy	Y	N	Heart condition/murmur	Y	N	Skin disorder	Y	N
Chronic Ear Infection	Y	N	Hepatitis	Y	N	Snoring	Y	N
Cognitive Delay	Y	N	HIV	Y	N	Autism/sensory issues	Y	N
Delayed Speech Dev	Y	N	Hyperactivity/ADHD	Y	N	Tuberculosis	Y	N
Developmental delay	Y	N	Joint Disease	Y	N	Tumors	Y	N
Diabetes	Y	N	Kidney Disease	Y	N	Transplants	Y	N

Please explain all yes answers and/or other medical issues not listed above: ______________________________

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Has your child had problems when having previous dental work? Y N *If yes, please explain:* ______________

____

Diet/Snack habits or concerns: ____

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Because your child is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before any/all diagnosed dental treatment is performed by our pediatric dentist. The signature below of the parent or guardian authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, the signee will be responsible for any fees associated with this child for dental care.

Signed: ____________________ Date: ________ Signed (Dr/Hyg) ____________________ Date _______

(Verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.)

Updated: ___________ Sig: (Patient) ______________________ Sig: (Dr/Hyg) ____________________

Updated: ___________ Sig: (Patient) ______________________ Sig: (Dr/Hyg) ____________________