

Medical History:

Has your child ever had any of the following medical Problems?

| | | |
|-----------------------------|---------------------------|-----------------------------|
| Y N Allergies | Y N Convulsion/Epilepsy | Y N Thyroidism |
| Y N Anemia | Y N Diabetes | Y N Lung Problems |
| Y N Asthma | Y N Drug/Alcohol Abuse | Y N Mental Disorder |
| Y N Bleeding Disorder | Y N Fainting | Y N Nervous System Disorder |
| Y N Bronchitis | Y N Handicap/Disabilities | Y N Rheumatic Fever |
| Y N Cancer/Chemotherapy | Y N Hearing Impairment | Y N Speech Disorder |
| Y N Cerebral Palsy | Y N Hepatitis | Y N Tuberculosis |
| Y N Congenital Heart Defect | Y N HIV/AIDS | Y N ADD/ADHD |
| Y N Heart Murmur | Y N OCD | Y N ODD |
| Y N Downs Syndrome | Y N Autism | Y N Kidney Problems |

Has your child experienced any other physical or mental disorder that is not listed above? Yes ___ No ___

If yes, please describe: _____

Parents, if yes to any of the above please explain: _____

Doctor's Comments: _____

Is your child allergic to any of the following drugs?

Y N Penicillin Y N Amoxicillin Y N Erythromycin Y N Codeine Y N Dental Anesthetic

Is your child allergic to any other drugs? Yes ___ No ___ If Yes, please list _____

Is your child allergic to latex, red dye, eggs, or anything we need to be aware of? Yes ___ No ___ If Yes, please list _____

Is your child presently under the care of a physician for any illness? Yes ___ No ___ If Yes, please explain _____

List any drugs or medicines presently being taken: _____

Has your child ever been hospitalized? Yes ___ No ___ If Yes, please give reasons and dates (s) _____

Dental History:

Do you want complete treatment for your child? Yes ___ No ___

Why did you bring your child to see us today? _____

Is this your child's first visit to the dentist? Yes ___ No ___

Has your child ever had a serious/difficult problem associated with previous dental work? Yes ___ No ___ If Yes, please explain _____

Date of last dental visit _____ Name of Dentist _____ For what service? _____

Were any x-rays taken? Yes ___ No ___ If Yes, have x-rays been sent to our office? _____ Date requested _____

How do you expect your child to behave in our office? _____

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

Y N Do you assist child with tooth brushing?

Y N Is dental floss used?

Y N Does your child take any type of fluoride supplement?

Y N Any mouth habits? (Thumb sucking, nail biting, mouth breather, nursing bottle habits, pacifier, etc.)

Y N Any injuries to mouth, teeth, head? Dates _____

Thank you for your help. If there is any information that you feel might be of value to us in the treatment of your child, please add it here: _____

I give my consent to needed dental treatment and the use of proper and acceptable methods to complete said treatment for my child, (child's full name) _____. I accept responsibility for payment of services rendered.

Signed (Parent of Guardian) _____ Date _____