

Patient Name: _____

CHILD'S HEALTH HISTORY

Child's physician _____ Address _____

Phone # _____

Is the child under the care of a physician now? ____ Yes ____ No

Please describe _____

Is your child taking any medications or drugs? ____ Yes ____ No

Medication _____ Dose _____

Medication _____ Dose _____

Has your child been in the hospital or ever had surgery? ____ Yes ____ No

Please describe _____

Does your child have a history of:

Anemia

Epilepsy

HIV-AIDS

Asthma

Fainting

Kidney disease

Birth Defects

Fever blisters

Liver disease

Cancer

Hay fever

Neurologic problems

Convulsions, seizures

Hearing problems

Prolonged bleeding

Diabetes

Heart problems

Sinus

Digestive disorders

Heart murmur

Tuberculosis

Hepatitis

Is your child allergic or reacted adversely to any of the following:

Any metals _____

Erythromycin

Local anesthetic

Any food _____

Ibuprofen

Nitrous oxide

Aspirin

Latex

Penicillin

Are you aware of being allergic to any other medications or substances? _____

Is there any other medical or dental information you feel we should know? _____

The undersigned authorizes the dentist to take necessary x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis. I also authorize the dentist to perform all forms of treatment that may be indicated. I understand there are certain risks with the use of anesthetic agents. I understand I am responsible for payment of dental services and I will assign insurance benefits to the dentist.

Signature _____