Lee T. Brown, DDS
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Brown & Gettings, DDS
Creating Beautiful Smiles

8191 Beckett Park Drive
West Chester, OH 45069
(513) 860-3660

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 ____

Creating healthy beautiful smiles in a family environment