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## DENTAL/MEDICAL HISTORY

Has your child been to the dentist before?  Yes  No

If yes, the approximate date of last visit: \_\_\_\_\_

Are there any dental problems that you are aware of at present?  Yes  No If yes, please explain: \_\_\_\_\_

Does your child brush his / her teeth daily?  Yes  No

Please rate your child's oral health:  Good  Fair  Poor

Is your child currently under the care of a physician?  Yes  No

Child's physician: \_\_\_\_\_

His / Her phone #: \_\_\_\_\_

The approximate date of last visit: \_\_\_\_\_

Please rate your child's medical health:  Good  Fair  Poor

**Is your child allergic to any drugs or other things?**  Yes  No

If yes, please list: \_\_\_\_\_

Is your child taking any prescription drugs?  Yes  No

If yes, please list: \_\_\_\_\_

**Does your child require antibiotics before dental treatment?**  Yes  No

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Has your child ever had any of the following medical conditions or problems?

- Y  N Any Hospital Stays
- Y  N Any Operations
- Y  N Bleeding Problems of Any Kind
- Y  N Cancer
- Y  N Convulsions / Epilepsy
- Y  N Diabetes
- Y  N Hearing Impairment
- Y  N Heart Murmur
- Y  N Heart Problems of Any Kind
- Y  N Hemophilia
- Y  N HIV+ / AIDS
- Y  N Hyperactive
- Y  N Rheumatic / Scarlet Fever

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**In the event of any emergency, whom should we contact?**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone #2: \_\_\_\_\_

Are there any other medical conditions or problems relating to your child?  Yes  No

If yes, please list: \_\_\_\_\_



I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.



**The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.**

Signature of parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**T**hank you for filling out this form completely. It will enable us to give your child the best dental care possible. If you or your child have any questions, please feel free to ask us at any time.