

## Health History

Has your child ever had any of the following problems? *Please circle your answer*

Allergies to drugs or medications.....	YES	NO	Hemophilia.....	YES	NO
Anemia .....	YES	NO	Hepatitis.....	YES	NO
Asthma.....	YES	NO	High blood pressure.....	YES	NO
Autism.....	YES	NO	High fevers.....	YES	NO
Behavior problems.....	YES	NO	HIV+ / AIDS.....	YES	NO
Birth defects.....	YES	NO	Kidney disease.....	YES	NO
Cancer or tumors.....	YES	NO	Latex allergy.....	YES	NO
Cerebral Palsy.....	YES	NO	Learning disability.....	YES	NO
Convulsions (seizures) .....	YES	NO	Liver disease.....	YES	NO
Diabetes.....	YES	NO	Nutritional problem.....	YES	NO
Ear infection.....	YES	NO	Mental retardation.....	YES	NO
Epilepsy.....	YES	NO	Rheumatic / Scarlet fever.....	YES	NO
Excessive/ prolonged bleeding.....	YES	NO	Sickle Cell Disease or Trait.....	YES	NO
Fainting/ dizziness.....	YES	NO	Speech problems.....	YES	NO
Handicaps/ disabilities.....	YES	NO	Tonsillitis.....	YES	NO
Heart murmur.....	YES	NO	Tuberculosis.....	YES	NO
Heart trouble.....	YES	NO	Vision problems.....	YES	NO
Hearing problems.....	YES	NO			

Any special problems not listed above? \_\_\_\_\_

Please list all medications that your child is **currently** taking \_\_\_\_\_

Is your child currently under the care of a physician? YES NO

Describe \_\_\_\_\_

Physician name and phone number \_\_\_\_\_ (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

Are immunizations up to date? YES NO

Were there any problems during pregnancy, delivery or during the first year of your child's life? YES NO

Describe \_\_\_\_\_

## Dental History

Does or has your child have or had any of the following problems?

Lip sucking/ biting habits.....	YES	NO	Any problem with previous dental work....	YES	NO
Nail biting habits.....	YES	NO	Describe _____		
Thumb/ finger sucking habits.....	YES	NO	Hospitalization.....	YES	NO
Nursing bottle habits.....	YES	NO	Injuries to face, mouth or teeth.....	YES	NO
Pain or tenderness in the jaw joints (TMJ) .....	YES	NO	Describe _____		

*(We are sorry but we need to add the following few lines. Please read carefully and sign and date. Thank you)*

- I understand the above information is necessary to provide my child with the dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
- I hereby authorize doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my child's dental needs.
- I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (Name of the patient) \_\_\_\_\_.
- I understand that all responsibility for payment for dental services provided in this office for my child is mine, due and payable at the time services are rendered unless other arrangements have been made. In the events payments are not received by the agreed upon dates, I understand that a 1-1/2 percent finance charge (18% APR) may be added to my account, in addition to any collection charges.
- I understand that where appropriate, credit bureau reports may be obtained.
- I understand that it is my responsibility to advise the office of any changes in the information contained on this form.

*(We apologize again for the above few lines)*

Parent or responsible party \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to the child \_\_\_\_\_ Witness \_\_\_\_\_

Periodic update of information

Parent's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Doctor's Signature \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Doctor's Signature \_\_\_\_\_