Child Medical History

The following information is important for the patient's maximum safety, comfort and optimum dental care. This information will be held in the utmost confidence by this office. *Please circle yes or no to the following*:

1. Is the patient presently under the care of a physician? ..... Yes No
2. Has the patient ever had abnormal bleeding following a wound? ..... Yes No
3. Is the patient allergic to Penicillin, Novocain or any other medication? ..... Yes No
   If so, what?_____
4. Is the patient allergic to anything other than medicine? (e.g. latex or metals)? ..... Yes No
   If so, what?_____
5. Is the patient presently taking any medication?. ..... Yes No
   If so, what?_____
6. Does the patient have any limiting disabilities? ..... Yes No
   If so, what?_____
7. Has the patient ever had any of the following?

a) Rheumatic Fever	Yes	No	h) Mitral Valve Prolapse	Yes	No
b) Rheumatic Heart Disease	Yes	No	i) Tuberculosis	Yes	No
c) Congenital Heart Disease	Yes	No	j) Diabetes	Yes	No
d) Blood Disorder	Yes	No	k) Liver Trouble or Jaundice	Yes	No
e) Epilepsy or Convulsions	Yes	No	l) Heart Murmur	Yes	No
f) Asthma or Hay Fever	Yes	No	m)Hepatitis	Yes	No
g) Eczema or Hives	Yes	No	n) HIV /AIDS	Yes	No

8. Does the patient have any history of missing teeth? ..... Yes No
9. Has the patient been under the care of a physician for any major illness or injury other than those noted above? ..... Yes No

If so, what?_____

I give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes of dental treatment for the child named above in my absence.

I also acknowledge that I have been given or offered a copy of the offices “Notice of Privacy Practices”.

_____ _____

Signature of Parent or Guardian Date