PATIENT MEDICAL HISTORY

PATIENT NAME: _____ **BIRTH DATE**:_____

Although dental personnel primarily treat the area in and around the mouth, the mouth is a part of the entire body and problems, concerns or medication being taken is important information. Please answer the below to the best of your ability.

Is your child in good health?	QYes QNo
Has your child been seen by a medical provider in the last 12 month?	QYes QNo
Is your child under a physician's care right now?	QYes QNo
Is your child taking any medication?	QYes QNo
Has your child been hospitalized or required surgery?	QYes QNo

MEDICAL HISTORY

Anemia	QYes QNo	Cerebral Palsy	QYes QNo	Thyroid	QYes QNo
Asthma	QYes QNo	Autism	QYes QNo	Tumor	QYes QNo
Bleeding Disorder	QYes QNo	Drug Reactions	QYes QNo	Hydrocephalus	QYes QNo
Cancer	QYes QNo	Liver	QYes QNo	Seizures	QYes QNo
Diabetes	QYes QNo	Kidney	QYes QNo	Vison Impairment	QYes QNo
Speech Disorder	QYes QNo	Endocrine	QYes QNo	Behavior Issues	QYes QNo
ADHD	QYes QNo	Hepatitis	QYes QNo	Headaches	QYes QNo
Learning Disability	QYes QNo	Heart Defects/Murmur	QYes QNo	Developmental Delay	QYes QNo

ALLERGIES

Food QYes QNo Latex QYes QNo

Drug QYes QNo <if yes> please list: _____

Other QYes <If yes> please list: _____

SIGNATURE By marking YES, I certify the above information was completed, reviewed and signed by:

Mother QYes Father QYes Legal Guardian QYes Patient (18yr or older) QYes

I authorize routine dental diagnostic procedures for my child (or the child I am a guardian of). I accept the proposed treatment plan and authorize the dental staff to perform the necessary dental services. I understand I am responsible for services not insured and for any outstanding balance. I further authorize the dentist and/or staff to release any dental/medical information including but not limited to x-rays and images, necessary to facilitate the care of the above mentioned child/minor. I understand that the information provided is correct to the best of my knowledge and will be held in confidence. I further understand it is my responsibility to inform the office if any of the above information changes.

PRINTED NAME: _____ SIGNATURE: _____ DATE: _____