Drs. Love & Miller, P.C.

Clear Form

Child's Medical History

Child's Name		**Nickname**	
Today's Date		**Birth Date**	
Patient Account No.		**Medical Alert**	

1. Is your child under the care of a physician? ☐ Yes ☐ No
   If yes, please describe: _____
2. Child's physician name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
3. Is your child taking any medications? (prescription or over-the counter) ☐ Yes ☐ No
   If yes, please describe: _____
4. Have you ever been told your child needs antibiotics or premeds before treatment? ☐ Yes ☐ No
5. Does your child have any allergic (or adverse) reaction to any medication or other substance? ☐ Yes ☐ No
   If yes, please describe: _____
6. Are you child's immunizations current? ☐ Yes ☐ No
7. List any hospitalizations, surgeries, serious illnesses: When?

   _____ _____

   _____ _____

   _____ _____
8. Indicate which of the conditions your child has now or ever has had.

Abnormal Bleeding	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Latex Sensitivity	☐ Yes ☐ No
AIDS/HIV Positive	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Measles	☐ Yes ☐ No
Allergies or Hives	☐ Yes ☐ No	Handicaps/Disabilities	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Mumps	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hearing Problems	☐ Yes ☐ No	Neurological Disorders	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Psychiatric/Psychological	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Rheumatic/Scarlet Fever	☐ Yes ☐ No
Congenital Heart Disease	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Stomach Problems	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Kidney/Liver Problems	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No

Other, please list: _____

I understand the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication.

Patient/Guardian Signature _____ Date _____

Dentist's Review

Dentist's Signature _____ Date _____