



1. Your child's physician name _____ Phone _____
Address _____ City _____ State _____ Zip _____

2. Is your child under the care of a specialist? Yes No

If yes, please describe: _____

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 list: _____

6. Are your child's immunizations current? Yes No

List any hospitalizations, surgeries, serious illnesses

When?

_____	_____
_____	_____
_____	_____

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

Check "yes" or "no"	
Abnormal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS/HIV positive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies or hives	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken pox	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Handicaps/disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No

Check "yes" or "no"	
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney/liver problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Latex sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychological condition	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic/scarlet fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, 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 _____