

Your Child's Name _____ Nickname _____

Your Child's SS# _____ Your Child's Birth Date _____

Your Child's Physician: Name _____ Phone: _____

Address _____

Is your child under the care of a physician? _____

Is your child taking any medications (prescription or over-the-counter)? _____

Have you ever been told your child needs antibiotics or premeds before treatment? _____

Has your child ever had any allergic (or adverse) reaction to any medication or other substance? _____

If yes, please list _____

Are your child's immunizations current? _____

List any hospitalizations, surgeries, serious illnesses	When?
_____	_____
_____	_____
_____	_____

Indicate which of the conditions your child has now or ever has had. Circle "Y" (yes) or "N" (no) for each item

AIDS / or HIV Positive	Y N	Epilepsy / Seizures	Y N	Nervous Disorder	Y N
Asthma / or Breathing Problems	Y N	Handicaps / Disabilities	Y N	Hepatitis A B C (circle)	Y N
Anemia	Y N	Hay Fever	Y N	Psychiatric/Psychological	Y N
Allergies or Hives	Y N	Hearing Problem	Y N	Rheumatic / Scarlet Fever	Y N
Bleeding Disorder	Y N	Heart Condition	Y N	Sickle Cell Disease / or Trait	Y N
Brain Injury	Y N	Kidney Trouble	Y N	Stomach Problems	Y N
Cancer	Y N	Liver Problems	Y N	Tuberculosis	Y N
Cerebral Palsy	Y N	Latex Sensitivity	Y N	Behavioral Problems	Y N
Chicken Pox	Y N	Lung Problems	Y N	Chronic Ear Infections	Y N
Congenital Heart Disease	Y N	Measles/Mumps	Y N	Tonsillitis	Y N
Diabetes	Y N	Mononucleosis	Y N	Heart Murmur	Y N

Does / Has your child have any other disease, condition, or problem not listed above? 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 who may release such information to you. I will notify the dentist of any change in my child's health or medication.

Signature of Parent / Guardian _____ Date _____

Dentist's Signature _____ Date _____