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CHILD'S HEALTH HISTORY

Child's physician _____ **Address**_____

Phone #_____

Is the child under the care of a physician now? ____ **Yes** ____**No**

Please describe _____

Is your child taking any medications or drugs? ____ **Yes** ____**No**

Medication_____ **Dose** _____

Medication_____ **Dose** _____

Has your child been in the hospital or ever had surgery? ____ **Yes** ____**No**
Please describe_____

Does your child have a history of:

Anemia	**Epilepsy**	**HIV-AIDS**
Asthma	**Fainting**	**Kidney disease**
Birth Defects	**Fever blisters**	**Liver disease**
Cancer	**Hay fever**	**Neurologic problems**
Convulsions,seizures	**Hearing problems**	**Prolonged bleeding**
Diabetes	**Heart problems**	**Sinus**
Digestive disorders	**Heart murmur**	**Tuberculosis**
	Hepatitis	

Is your child allergic or reacted adversely to any of the following:

Any metals _____	**Erythromycin**	**Local anesthetic**
Any food _____	**Ibuprofen**	**Nitrous oxide**
Aspirin	**Latex**	**Penicillin**

Are you aware of being allergic to any other medications or substances? _____

_____

Is there any other medical or dental information you feel we should know? _____

_____

The undersigned authorizes the dentist to take necessary x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis. I also authorize the dentist to perform all forms of treatment that may be indicated. I understand there are certain risks with the use of anesthetic agents. I understand I am responsible for payment of dental services and I will assign insurance benefits to the dentist.

Signature _____

Creating healthy beautiful smiles in a family environment