## 4b (CHILD'S) MEDICAL HISTORY

Current Physical Condition? ❑ Good ❑ Fair ❑ Poor
Use tobacco in any form? ❑ Yes ❑ No
Taking any over-the-counter/prescription or herbal supplement drugs? ❑ Yes ❑ No
Please List Each One _____

_____

Has your child ever been hospitalized for any reason?
❑ Yes ❑ No
Is your child physically, emotionally or mentally impaired? ❑ Yes ❑ No
Please list any other medical condition(s) that your child has had:

_____

_____

Has a doctor ever told you that your child requires antibiotics prior to dental treatments? ❑ Yes ❑ No

### IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Yes | No | Aspirin | Yes | No | Erythromycin | Yes | No | Penicillin |
| Yes | No | Codeine | Yes | No | Jewelry/Metals | Yes | No | Tetracycline |
| Yes | No | Dental Anesthetics | Yes | No | Latex | Yes | No | Other |

Please list any other drugs/materials that you are allergic to:

_____

_____

### HAS YOUR CHILD EVER HAD ANY HISTORY OF, OR CONDITIONS RELATED TO, ANY OF THE FOLLOWING?

| | | | | | |
|---|---|---|---|---|---|
| Yes | No | Anemia | Yes | No | Hepatitis |
| Yes | No | Arthritis | Yes | No | HIV+/AIDS |
| Yes | No | Bladder | Yes | No | Immunizations |
| Yes | No | Bleeding Disorders | Yes | No | Kidney |
| Yes | No | Bones/Joints | Yes | No | Liver |
| Yes | No | Cancer | Yes | No | Measles |
| Yes | No | Cerebral Palsy | Yes | No | Mitral Valve Prolapse |
| Yes | No | Chicken Pox | Yes | No | Mononucleosis |
| Yes | No | Chronic Sinusitis | Yes | No | Mumps |
| Yes | No | Cold Sores/Fever Blisters | Yes | No | Pregnancy (teens) |
| Yes | No | Congenital Heart Defect | Yes | No | Psychiatric Problems |
| Yes | No | Diabetes | Yes | No | Rheumatic Fever |
| Yes | No | Ear Aches | Yes | No | Seizures |
| Yes | No | Epilepsy | Yes | No | Sickle Cell |
| Yes | No | Fainting | Yes | No | Thyroid |
| Yes | No | Growth Problems | Yes | No | Tobacco/Drug Use |
| Yes | No | Hearing | Yes | No | Tuberculosis |
| Yes | No | Heart Murmur | Yes | No | Veneral Disease |
| Yes | No | Heart Surgery | | | |

Please list any other medical condition(s) that you have had:

_____

_____

## 5 DISCLAIMER

For the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. The undersigned hereby authorizes Doctor, in order to make a thorough diagnosis of the patient's dental needs, to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor. I understand that the Doctor will advise me of any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) _____. I also understand that the Doctor may choose and employ such assistance as deemed fit. I further understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time that services are rendered unless financial arrangements have been previously made. I further understand that I am entitled to a 5% courtesy if payment for services is made within 24 hours. All other financial arrangements, insurance, credit cards, or time payments, are not subject to that courtesy. A 1 ½ % monthly finance charge will be applied to all accounts over 60 days past due. There will be a $25.00 service charge on all returned checks. We require 24 hours notice for cancellations. If a 24 hour notice is not given, it will be necessary to charge $30.00 for each appointment cancelled. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

_____

Signature Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

OAKVILLE DENTAL CARE

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____
Doctor's comments _____

_____