SENSITIVE CARE KIDS
PEDIATRIC DENTISTRY

MEDICAL AND HEALTH HISTORY

Child's Physician _____ City_____ Tel. _____

Date of last physical examination _____ Results _____

	YES	NO
1. Is your child under the care of a physician (other than routine care) now? _____	❑	❑
Name of Dr. _____		
2. Does your child take any medication or supplements? _____	❑	❑
_____		
3. Has your child ever been hospitalized? _____	❑	❑
_____		
4. Has your child ever had surgery? _____	❑	❑
Reason: _____		
5. Is there anything artificial placed in your child's body, such as pins, shunts, rods, etc.? _____	❑	❑
6. Does your child have any allergies (i.e., penicillin, latex, nuts, etc.)? _____	❑	❑
7. Are there any physical problems? _____	❑	❑
8. Were there problems at or before birth _____	❑	❑
10. Does your child have any bleeding disorders? _____	❑	❑

❑ Anemia	❑ Diabetes	❑ Heart / Heart Murmur	❑ Malignancies
❑ Asthma	❑ Epilepsy	❑ Hepatitis	❑ Rheumatic Fever
❑ Cerebral Palsy	❑ Frequent Infections	❑ HIV	❑ Thyroid
❑ Chronic Sinus	❑ Headaches	❑ Kidney	❑ Tuberculosis
❑ Convulsions	❑ Hearing	❑ Liver	❑ Other

Please describe any current medical treatment including medications, pending surgery, recent injuries or any other information we should be aware of: _____

_____

SENSITIVE CARE KIDS
PEDIATRIC DENTISTRY

DENTAL HISTORY

Specific Concerns:_____

Is this your child's first dental visit? (Yes or No) _____ Were X-rays taken: Yes ❑ No ❑ Date of X-rays_____

If no, previous dentist's name:_____ Date of last visit: _____

Do you have well or city water?_____

	YES	NO
Any unhappy dental experiences? _____	❑	❑
Any oral habits - thumbsucking, nail biting, pacifier, etc.? _____	❑	❑

Child's attitude toward dentistry:_____

Parents' attitude toward dentistry: _____

PERMIT FOR TREATMENT UPON A MINOR

The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my child's medical status. I, being the parent or guardian of the above minor patient, do request and authorize the performance of dental services for this patient, and the performance of whatever procedures or techniques the Doctor may deem necessary during performance of any operation or treatment.

I authorize the administration of anesthetics or analgesics which may be deemed advisable by the Doctor. Furthermore, I understand as the parent or guardian who accompanies the child I will be responsible for all financial obligations incurred on this child for dental treatment.

I give my permission to use these records for consultations and educational purposes.

This information was provided by and discussed with:_____
(Signature and relationship to patient)