



# MEDICAL HISTORY

Minor/Child's Physician \_\_\_\_\_ City/State \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_

YES NO

Is Minor/Child under care of physician now? .....   Medications \_\_\_\_\_

Receiving any medication or drugs? .....   \_\_\_\_\_

Ever been hospitalized? .....   \_\_\_\_\_

Ever had surgery? .....   Allergies \_\_\_\_\_

Is there excessive bleeding when cut? .....   \_\_\_\_\_

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK (✓)

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> A.I.D.S./H.I.V.  | <input type="checkbox"/> Cerebral Palsy     | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Chicken Pox        | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Liver Disease  | <input type="checkbox"/> Sinus Problems  |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Convulsions        | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles        | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Heart Problems   | <input type="checkbox"/> Mononucleosis  | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Other           |

## EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

I certify that my minor/child is covered by insurance with \_\_\_\_\_

\_\_\_\_\_  
Name of Insurance Company(ies)

and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

## UPDATE

(To be completed at later visit)

Has there been any change in patient's health since last dental appointment?  Yes  No

If yes, please describe \_\_\_\_\_

Is patient taking any new medications?  Yes  No If yes, please list \_\_\_\_\_

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_ Dentist Signature \_\_\_\_\_

