Why have you brought your child to visit us today? _____

Is this your child's first visit to the dentist? _____

Has your child ever had a serious problem with a previous dental treatment? (If so, please explain) _____

Please circle Y for Yes and N for No

Y N Does your child suck his/her thumb or pacifier
Y N Does your child take fluoride drops, tablets or rinse?

Child's Medical Health

Your child's Physician _____ Phone _____

Has your child ever been hospitalized? (If so, please give reason) _____

Is your child allergic to: **Please circle Y for Yes and N for No**

Y	**N**	Local injected anesthetics (Novocaine)	**Y**	**N**	Codeine
Y	**N**	Penicillin	**Y**	**N**	Sulfites/Sulfides
Y	**N**	Latex, Metals, Plastics			
Y	**N**	Aspirin	**Other**		_____

Has your child ever been treated for: **Please circle Y for Yes and N for No**

Y	**N**	Asthma	**Y**	**N**	Fainting spells
Y	**N**	Bleeding disorder	**Y**	**N**	Prolonged bleeding
Y	**N**	Diabetes	**Y**	**N**	Hepatitis
Y	**N**	Arthritis	**Y**	**N**	Emotional problems
Y	**N**	Hearing loss	**Y**	**N**	Rheumatic Fever
Y	**N**	Heart disease	**Y**	**N**	Seizures
Y	**N**	Heart murmur	**Y**	**N**	Lung Disease/TB
Y	**N**	Joint replacement or artificial prosthesis			

Has your child had any serious illness not listed above? **Y N** If yes please explain _____

Is there anything else you would like us to know about your child?

_____

Medications

Does your child usually take an antibiotic prior to dental treatment? **Y N**

List all medications your child is currently taking (or has recently taken) and the condition for which they are prescribed:

Medication: _____ Dosage _____ Condition _____

Medication: _____ Dosage _____ Condition _____

Medication: _____ Dosage _____ Condition _____

In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____

Name of nearest relative not living with child _____ Phone _____

Medical health reviewed by:

X _____
Doctor's Signature

X _____
Doctor's Signature

X _____
Doctor's Signature

If Patient is a minor:

X _____
Parent/Guardian's Signature

X _____
Parent/Guardian's Signature

X _____
Parent/Guardian's Signature

Power of Attorney

I, the undersigned, hereby authorize _____

to bring in _____ to receive dental treatment.

Signature of Parent or Guardian X _____ Date _____

I give my permission for this Office to administer any necessary treatment in an event of a medical emergency.

Signature of Parent or Guardian X _____ Date _____

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.