River City Dental

CHILD'S MEDICAL HISTORY
(Age 17 and Under)

Patient Name:	Date of Birth:

Has the child had any history of, or conditions related to, any of the following? Please mark the ones that apply:

Anaphylaxis	☐	Emotional Impairment	☐	Physical Impairment	☐
Arthritis	☐	Fainting	☐	Stomach Problems	☐
Asthma	☐	Growth Problems	☐	Speech Impairment	☐
Bladder Problems	☐	Herpes/ Cold Sores	☐	Thyroid Disease	☐
Bleeding Disorders	☐	Handicaps/Disabilities	☐	Tonsillitis (Frequent)	☐
Bones/Joints Problems	☐	Hearing Impairment	☐	**Use of any of the following:**	
Cancer	☐	Heart Murmur	☐	Birth Control	☐
Cerebral Palsy	☐	Hepatitis A,B,C,D	☐	Drug Use	☐
Chicken Pox	☐	HIV/AIDS	☐	Drug Addiction (past)	☐
Chronic Sinusitis	☐	Immunization Problems	☐	Marijuana use	☐
Congenital Heart Disease	☐	Kidney Problems	☐	Tobacco Products	☐
Convulsions/Epilepsy	☐	Liver Problems	☐		
Diabetes	☐	Mononucleosis	☐	Are Fluoride Supplements used?	☐
Ear Aches	☐	Pregnancy	☐		

Other Conditions or Concerns:_____

_____

Please List the name and phone number of the child's physician:

Name of Physician_____ Phone_____

Is the child allergic to:

Amoxicillin ☐ Penicillin ☐ Foods ☐ Other: _____

Dental History:

Previous Dentist: _____

First dental appointment? _____

Does the child use a pacifier, suck thumb/blanket? _____

I understand that providing incorrect information may be dangerous to my child's health. It is my responsibility to inform my child's dental provider of any changes in his/her medical status. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____

Parent/Guarantor Signature **Date** **Dentist Signature**