

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

Is Minor/Child under care of physician now? _____ YES NO
 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 SO 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 |

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

RELEASE AND ASSIGNMENT

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 doctor 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 visits)

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? _____ If so, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

UPDATE (To be completed at later visits)

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? _____ If so, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____