HEALTH HISTORY

Child's physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	Yes	No		Yes	No
Is child under care of physician now _____	☐	☐	Does child have good physical coordination _____	☐	☐
Is child receiving any medication or drugs _____	☐	☐	Are there any emotional problems _____	☐	☐
Is there any excessive bleeding when cut _____	☐	☐	Summary (for doctor's use) _____		
Has child ever been hospitalized _____	☐	☐			
Has child ever had surgery _____	☐	☐			
Is there any allergy to penicillin or other drugs _____	☐	☐			
Are there other allergies: food - pollen - animals - dust - other	☐	☐			

Has child any history of or difficulty with any of the following:

___ Anemia	___ Chronic sinus	___ Hearing	___ Mastoid	___ Thyroid
___ Asthma	___ Convulsions	___ Heart	___ Measles	___ Tuberculosis
___ Bladder	___ Diabetes	___ Kidney	___ Mononucleosis	___ Venereal disease
___ Cerebral Palsy	___ Epilepsy	___ Liver	___ Mumps	___ Other
___ Chicken pox	___ Fainting	___ Malignancies	___ Rheumatic fever	

Summary: (for doctor's use)

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

	Yes	No
May we request release of your child's medical records for our reference _____	☐	☐

This information was discussed with and given by _____

Relation to child _____

I have reviewed the following treatment plan and I authorize release of any information relating to this claim.

_____
Signed (Patient, or parent of minor)

I authorize my insurance benefits to be paid directly to the dentist. I acknowledge my responsibility for any unpaid balance whether I have insurance or not due at the time of service unless other arrangements have been confirmed.

_____
Signed (insured person)