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General Health Information

Has the child ever had a serious / difficult problem with previous dental work? _Y _N

Is the child's water fluoridated? _Y _N

Is the child taking fluoridated supplements? _Y _N

Does the child brush his / her teeth daily? _Y _N

Floss his / her teeth daily? _Y _N

Has the child ever had any tenderness in his / her jaw joint (TMJ / TMD)? _Y _N

Is the child currently under the care of a physician? _Y _N

Child's Physician: _____

Phone:_____Last Visit:_____

Please list **all medications** the child is currently taking (including Prescription, OTC and Herbs): _____

_____

_____

_____

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Has the child ever had any of the following medical problems?

If YES, please check.

__Abnormal Bleeding
__ADD / ADHD
__Allergies
__Any Hospital Stays
__Any Operations
__Artificial Bones / Joints
__Asthma
__Cancer
__Congenital Heart Defect
__Convulsions / Epilepsy
__Diabetes
__Handicaps / Disabilities
__Hearing Impairment
__Heart Murmur
__Hemophilia
__Hepatitis
__HIV / AIDS
__Kidney / Liver Problems
__ Rheumatic / Scarlet Fever
__Sickle Cell Disease
__Tuberculosis

Please discuss any serious medical problems that child has had: _____

_____

_____

Is the child allergic to any of the following:

__Any Anesthetic
__Any Metal
__Aspirin
__ Codeine
__Latex
__Other Antibiotic
__Penicillin
__Other _____

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I understand this office will file insurance claims on my behalf as a courtesy to me. I understand that I, in conjunction with any insurance benefits, am responsible for payment of dental services provided to me. I understand that if a change to my scheduled appointment becomes necessary, a 24 hour notice is required to avoid a cancellation fee.

Signature of Parent or Guardian:_____Date:_____

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

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