Is child in good health?	○ Yes ○ No	
Is your child under the care of a Physician? If yes, Name of Physician and since when and why?	○ Yes ○ No	If yes
Has your child had any serious illness? If yes, When and Why?	○ Yes ○ No	If yes
Has Child had Surgery? If yes, Explain?	○ Yes ○ No	If yes
Is surgery contemplated? If yes, what type?	○ Yes ○ No	If yes
Is the child allergic to penicillin, antibiotics or other drugs? If yes which ones?	○ Yes ○ No	If yes
Have you ever been told that your child should have antibiotics before all dental visits?	○ Yes ○ No	

If your child has had any of the following, please indicate below. Please explain any questions marked "YES" in space below:

Loss of Consciousness ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Hemophilia ○ Yes ○ No	Special Needs ○ Yes ○ No
Kidney Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Convulsions ○ Yes ○ No	Bladder Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Psychiartric Treatment ○ Yes ○ No	Liver Disease ○ Yes ○ No	Breathing Difficulties ○ Yes ○ No
Seizures ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No	Pneumonia ○ Yes ○ No	Epilepsy ○ Yes ○ No
Sickle Cell Disease ○ Yes ○ No	Nose/Throat Disorders ○ Yes ○ No	Emotional Problems ○ Yes ○ No	AIDS ○ Yes ○ No
Cleft Lip/Palate ○ Yes ○ No	Alcohol Dependency ○ Yes ○ No	Hepatitis ○ Yes ○ No	Recurrent Headaches ○ Yes ○ No
Chemical Dependency ○ Yes ○ No	Skin Disease ○ Yes ○ No	Eye Disorders ○ Yes ○ No	Hyperactivity ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Ear Disorders ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Arthritis ○ Yes ○ No	Attention Deficit Syndrome ○ Yes ○ No	Lung Disease ○ Yes ○ No	Bone Disorders ○ Yes ○ No
Endocrine Disorders ○ Yes ○ No	Glandular Problems ○ Yes ○ No	Diabetes ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Heart Murmur ○ Yes ○ No	Heart Condition ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No	Anemia ○ Yes ○ No
Blood Disease ○ Yes ○ No	Bleeding Tendency ○ Yes ○ No		

In general, is your child progressing...?

☐ SLOW ☐ NORMAL ☐ ACCELERATED

CONSENT

As a minor child, it is necessary that signed permission be obtained from a parent or guardian before any dental care can begin. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete same treatment including diagnostic radiographs (x-rays). Protective restraints are only used when children may harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. If my child ever has a change in his/her health or his/her medications change, I will inform the doctor at the next appointment without fail. I will be responsible for the cost of this dental care. At no time will care be rendered to a child without informing parent or guardian of such care along with a written estimate of their financial obligation. For specific procedures, further information will always be provided.

I CERTIFY THAT THE INFORMATION ABOVE IS COMPLETE AND ACCURATE

Signature of Patient, Parent or Guardian:

X

Date:_____