MEDICAL INFORMATION

Child's pediatrician ____

Address ______________________________ Phone ______________ Date of last physical ________

Is your child in good health? ☐ Y ☐ N   Are your child's immunizations up to date? ☐ Y ☐ N

Is your child being treated for any condition presently ? ☐ Y ☐ N

If so, please explain ____

Is your child taking any medications or drugs? ☐ Y ☐ N

If so, please explain ____

Has your child ever been hospitalized or had surgery? ☐ Y ☐ N

If so, please explain ____

Does your child have any allergies or reactions to any medicatons? ☐ Y ☐ N

If so, please explain ____

Does your child have any allergies to the following?

☐ Pollen ☐ dust ☐ food ______________________ ☐ other______________________

Has your child ever been diagnosed as having any of the following conditions? Please check yes (Y) or no (N):

Y	N		Y	N		Y	N	
☐	☐	AIDS or HIV	☐	☐	Chronic headaches	☐	☐	Hepatitis or liver disease
☐	☐	Anemia	☐	☐	Chronic ear infections	☐	☐	Hyperactivity/A.D.D/A.D.H.D.
☐	☐	Asthma	☐	☐	Cleft lip/palate	☐	☐	Kidney disease
☐	☐	Autism	☐	☐	Congenital heart disease	☐	☐	Leukemia
☐	☐	Bladder conditions	☐	☐	Convulsions/seizures	☐	☐	Mental deficiency
☐	☐	Blood transfusions	☐	☐	Diabetes	☐	☐	Nutritional deficiency
☐	☐	Birth defects	☐	☐	Emotional disturbance	☐	☐	Oral ulcers
☐	☐	Bone or joint problems	☐	☐	Epilepsy	☐	☐	Orthopedic problems
☐	☐	Brain injury	☐	☐	Excessive gagging	☐	☐	Premature birth
☐	☐	Bruising easily	☐	☐	Fainting or dizziness	☐	☐	Rheumatic fever
☐	☐	Cancer or malignancies	☐	☐	Growth & development problems	☐	☐	Scoliosis
☐	☐	Cerebral palsy	☐	☐	Hearing/speech problems	☐	☐	Sickle cell anemia
☐	☐	Child abuse	☐	☐	Heart murmur	☐	☐	Tuberculosis
☐	☐	Chronic adenoid/tonsil infection	☐	☐	Hemophilia	☐	☐	Other________________

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that has not been covered.____

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DENTAL INFORMATION

Was your child bottle fed? ☐ Y ☐ N If yes, until age ________________

Was your child breast fed? ☐ Y ☐ N If yes, until age ________________

Has your child ever had any injuries to his teeth, mouth, head or jaws? ☐ Y ☐ N If yes, please describe________________

Does your child brush daily? ☐ Y ☐ N If yes, adult's assistance? ☐ Y ☐ N

Does your child floss daily? ☐ Y ☐ N If yes, adult's assistance? ☐ Y ☐ N

Does your child have any of the following mouth habits? ☐ finger /thumb sucking ☐ tongue thrusting ☐ pacifie ☐ lip sucking ☐ teeth grinder ☐ mouth breather ☐ nail biting

Does your child report any pain during chewing or while opening the mouth wide? ☐ Y ☐ N

Does your child receive fluoride in any of the following forms:

☐ In vitamins ☐ in water supply ☐ in tablets/drops dosage:____mg/day ☐ in toothpaste ☐ in rinse/gel

CONSENT FOR TREATMENT

I hereby authorize and direct Drs. Huang, Son, their associates and staff to provide dental care for my child.

I understand I will be provided with answers to any questions which may arise during the course of treatment.

Patient's name ____ Date ____________

Signature of parent/guardian ____

Print of parent/guardian ____