Child Medical History

MICHAEL D. FARMER, D.M.D.
general dentistry

CHILD'S NAME_____ **DATE OF BIRTH**_____

NAME OF MEDICAL PHYSICIAN_____

DATE OF LAST MEDICAL EXAMINATION_____

DOES CHILD HAVE OR EVER HAD:

ANEMIA……Y N ASTHMA…….. Y N

DIABETES……....Y N HEART MURMUR……..... Y N

HEPATITIS……...Y N RHEUMATIC FEVER…… Y N

ABNORMAL HEART CONDITIONS…….……...Y N

ABNORMAL BLEEDING FROM A CUT…….…Y N

OTHER_____

ALLERGIES

TO PENICILLIN OR ANY OTHER ANTIBIOTIC…….……..…Y N

PLEASE LIST_____

TO LOCAL ANESTHETIC…….……...….Y N

TO LATEX/RUBBER…….……..……...……..Y N

OTHER…….……..Y N

EXPLAIN_____

HAS YOUR CHILD BEEN HOSPITALIZED IN THE LAST 2 YEARS?.....Y N

IF SO, FOR WHAT?_____

IS YOUR CHILD UNDER THE CARE OF A PHYSICIAN NOW?.....Y N

IF SO, FOR WHAT?_____

ANY MEDICATION(S) BEING TAKEN NOW?.....Y N

IF SO, FOR WHAT?_____

OTHER PHYSICAL CONDITIONS?_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and /or health practitioners. I agree to notify the office of any health changes that may occur during the year.

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SIGNATURE OF PARENT OR GUARDIAN ***DATE***