PATIENT MEDICAL INFORMATION:

Has your child ever been diagnosed with or had any of the following problems?

	No	Yes-- Please Explain
Anemia		
ADD/ADHD		
Allergies to Drugs/Materials (e.g. Latex)		
Asthma/Reactive Airway		
Autism Spectrum		
Blood Transfusion		
Cancers/Tumors/Leukemia		
Cerebral Palsy		
Congenital Heart Disease		
Convulsions/Epilepsy		
Developmental Delay		
Diabetes		
Hearing or Speech Impairment		
Heart Murmur or Other Heart Condition		
Hemophilia or Bleeding Problems		
Hepatitis		
HIV+ or AIDS		
Hospital Stays or Complications		
Kidney or Liver Disease		
Tuberculosis		
Any conditions not listed above?		

Please list any medications your child is allergic to: ____

List any other allergies (e.g. Latex, Food allergies, etc.) ____

Current Medications: ____

Any other illness, past surgeries, or other health concerns? ____

CHILD'S PRIMARY CARE PHYSICIAN

Name _______________________ **Address** ______________________________________ **Phone** ___________________

DENTAL HISTORY

Age at first dental visit: __________ **History of oral or facial trauma?** ______________________________________

Has your child ever had an unpleasant dental experience? If yes, please explain: _________________________________

Does your child have a pacifier, thumb, or finger habit? ___________ **Do they take a cup/bottle to bed?** ___________

Please describe your child's behavior/temperament (circle all that apply)

Calm Shy Cooperative Temperamental Active Fearful Defiant Moody Loving Approachable

The questions on this form have been answered accurately and to the best of my knowledge. I understand providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the office of any changes in health status.

_____________________________________ __________________

Signature **Date**