DATE_____

CHILD'S NAME_____ BIRTHDATE_____ SEX_____

MOTHER'S NAME_____ FATHER'S NAME_____

ADDDRESS_____

NAME OF PHYSICAN_____

ADDRESS AND PHONE NUMBER OF CHILD'S PHYSICIAN_____

MEDICAL SUMMARY

ALLERGIES:

Local Anesthetic_____ Medicines_____

Penicillin_____ Other Antibiotics_____

Dust_____ Foods_____

Other_____

DOES YOUR CHILD HAVE ANY OF THESE DISEASES OR PROBLEMS?

Heart Trouble_____ Rheumatic Fever_____ Asthma_____ Bronchitis_____

Tuberculosis_____ Anemia_____ Bleeding Disorder_____

Hepatitis_____ Diabetes_____ Endocrine Disorders_____

Radiation Therapy_____ Kidney Infection_____ Seizure Disorders_____

Hospitalizations_____

Serious Illnesses or High Temperatures_____

Taking Any Medication Now_____ What_____

For What Reason Have You Taken Your Child To The Pediatrician Lately_____

CHILDHOOD DISEASES:

Measles_____ Mumps_____ Chicken Pox_____ Scarlet Fever_____

PAST DENTAL HISTORY:

Date Of Last Dental Visit_____

What Procedures Were Performed_____

How Did Your Child React To The Procedures_____

Signature Of Dental Staff_____