Child's Name:______________________ Date:__________

MEDICAL HISTORY:

1. Name of pediatrician______________________ Phone #__________
2. Is your child under the care of another physician/specialist? ☐ Yes ☐ No
   If yes, who? Since when and why?______________________
3. Is your child receiving any medication? ☐ Yes ☐ No
   List current medications:______________________
4. Is your child allergic to <u>any</u> drugs, such as penicillin? ☐ Yes ☐ No
   Explain:______________________
5. Does your child have other allergies? ☐ Yes ☐ No
   Explain:______________________
6. Has your child had any serious illness? ☐ Yes ☐ No
   Explain:______________________
7. Has your child ever had surgery or been hospitalized? ☐ Yes ☐ No
   When & Why?:______________________
8. Has your child had a history of any of the following? **Please check a response for each question:**
   - Heart trouble, heart murmur, or heart surgery.......... ☐ Yes ☐ No
   - Rheumatic fever or scarlet fever.......... ☐ Yes ☐ No
   - Asthma, TB, or lung problems.......... ☐ Yes ☐ No
   - HIV infection or AIDS.......... ☐ Yes ☐ No
   - Hemophilia or bleeding problems.......... ☐ Yes ☐ No
   - Sickle cell anemia/blood disorder.......... ☐ Yes ☐ No
   - Hepatitis or liver problems.......... ☐ Yes ☐ No
   - Kidney infection.......... ☐ Yes ☐ No
   - Diabetes.......... ☐ Yes ☐ No
   - Congenital birth defects.......... ☐ Yes ☐ No
   - Cleft lip or palate.......... ☐ Yes ☐ No
   - Malignant hyperthermia.......... ☐ Yes ☐ No
   - Is parent or patient pregnant?.......... ☐ Yes ☐ No
   - Thyroid or other glandular problems.......... ☐ Yes ☐ No
   - Latex or rubber allergy.......... ☐ Yes ☐ No
   - Cancer, tumor, leukemia.......... ☐ Yes ☐ No

     Describe:______________________
   - Epilepsy, seizures, fainting ☐ Yes ☐ No

     Describe:______________________
   - Autism, developmental delay, or Cerebral palsy ☐ Yes ☐ No

     Describe:______________________
   - Vision problems ☐ Yes ☐ No

     Describe:______________________
   - Speech or hearing problems ☐ Yes ☐ No

     Describe:______________________
   - Emotional or psychological problems ☐ Yes ☐ No

     Describe:______________________

COMMENTS: *(for office use only)*

Med hx updated in chart?	Dr. Initials

DENTAL HISTORY

1. When and where was your child's last dental visit? ______________________
2. What was the purpose of that visit?______________________
3. Did your child have difficulty cooperating? ☐ Yes ☐ No
4. Does your child take fluoride supplements? ☐ Yes ☐ No
5. Have any cavities been noted in the past? ☐ Yes ☐ No
6. Were any teeth (baby or permanent) removed by extraction? ☐ Yes ☐ No
7. Have there been any injuries to teeth, such as falls, chips, etc.? ☐ Yes ☐ No
8. Does your child have other siblings seen by us? ☐ Yes ☐ No If Yes, please list their name(s):______________________
9. Is there any additional information that we should know to help ensure a positive experience for your child? ______________________

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CONSENT

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I give my consent to Dr. Ross Fishman and his staff to perform such treatment, services, medication, behavior management techniques, local anesthesia and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

______________________ ______________________

Signature of Parent/Guardian Date