MONTAGUE DENTAL

Child - Web Form

Patient Health History

Patient Name _____ Date of Birth _____

Welcome to our office. Will you please fill out this short Health History form so we may be aware of any problems your child may have. Use the Additional Comments are at the end of the form to include any extra information. We look forward to working with you in maintaining your child's dental health.

Please circle YES or NO or fill in where appropriate:

Primary reason for this appointment _____

Name of child/minor's physician _____

Physician's address _____

Physician's phone number _____

Date of last visit to physician _____

Are your child/minor in good health? ..... Yes No

Has your child/minor been hospitalized within the past 5 years? ..... Yes No

Is your child/minor taking any medicine(s) including non-Prescription? ..... Yes No

Does your child/minor have or had any of the following diseases or problems?

a. Asthma ..... Yes No
b. Anemia ..... Yes No
c. AIDS/HIV ..... Yes No
d. Bladder problems ..... Yes No
e. Cancer ..... Yes No
f. Mental health problems ..... Yes No
g. Sinus trouble ..... Yes No
h. Asthma or hay fever ..... Yes No
i. Fainting spells or seizures ..... Yes No
j. Diabetes ..... Yes No
k. Hepatitis, jaundice or liver disease ..... Yes No
l. Cerebral Palsey or other developmental conditions ..... Yes No
m. Thyroid problems ..... Yes No
n. Respiratory problems ..... Yes No
o. Measles, Mumps, Mononucleosis ..... Yes No
p. Drug Alcohol Abuse ..... Yes No
q. Kidney trouble ..... Yes No
r. Tuberculosis ..... Yes No
s. Rheumatic Fever ..... Yes No
t. Blindness or Hearing Problems ..... Yes No
u. Epilepsy or neurological disorder ..... Yes No

Have you had abnormal bleeding? ..... Yes No

a. Have you ever required a blood transfusion? ..... Yes No

Does your child/minor have allergic reaction to:

a. Local anesthetics ..... Yes No
b. Penicillin or antibiotics ..... Yes No
c. Latex ..... Yes No
d. Food,enviromental (ie Hay Fever, Bee Stings, etc) ..... Yes No
e. Asprin ..... Yes No

f. Iodine ..... Yes No

g. Codeine or other narcotics ..... Yes No

h. Other ..... Yes No

Has your child/minor had any serious trouble associated with previous dental treatment? ..... Yes No

If so, explain _____

Do you have any other condition or disease you think we should know about,

but would prefer to discuss privately rather than writing them down? ..... Yes No

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 childs health. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any error or omissions that I may have made in the completion of this form. I certify that I am the parent, guardian or legal representative; and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the detnal staff to perform necessary dental services for the child/minor named above which are deemed advisable by the dentist whether or not I am present when the treatment is rendered.

X _____ _____

Signature of patient or guardian Date

MEDICAL HISTORY UPDATE:

SIGNATURE	COMMENTS	DATE
_____	_____	_____