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Dino Kid's DENTISTRY

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Patient Name :_____
Last First MI

Date of Birth: _____ Gender: _____

Date of last Medical exam: _____ Date of last Dental visit: _____

Is your child up to date on vaccinations? Yes ☐ No ☐ Medical Doctor's name: _____

Has your child ever been hospitalized? Yes ☐ No ☐ When and for what? _____

Medical problems: Has your child had any of the following medical problems?

	Yes	No		Yes	No
ADHD/ ADD	☐	☐	Heart murmur	☐	☐
Asthma	☐	☐	Heart problems	☐	☐
Autism	☐	☐	High blood pressure	☐	☐
Bleeding problems	☐	☐	Kidney problems	☐	☐
Developmental Delay	☐	☐	Epilepsy or seizures	☐	☐
Diabetes	☐	☐	Thyroid problems	☐	☐
AIDS or HIV	☐	☐	Hepatitis or liver problems	☐	☐
Tuberculosis	☐	☐	Birth Defects or Syndrome	☐	☐
Rheumatic Fever	☐	☐	Cancer	☐	☐
Pregnancy	☐	☐	Mental health problems	☐	☐

Does your child have any other medical problems not listed above?

_____

Is your child taking any medications? ☐ No ☐ Yes _____

Does your child have any allergies? ☐ No ☐ Yes _____

By signing below, I attest that this form is correct to the best of my knowledge and I am disclosing my child's medical conditions fully. I understand that failure to disclose medical conditions accurately may result in risk to my child. I give Dino Kid's Dentistry authorization to contact my child's physician to discuss my child's health history and planned treatment. I understand that it is my responsibility to keep Dino Kid's Dentistry updated with changes in my child's health history.

_____ _____ _____
Signature Name Date

_____ _____
Doctor's signature Date