SPECIAL DENTAL CARE

"Anesthesia Powered Dentistry"

Child Health History

PATIENT INFORMATION (CONFIDENTIAL) Today's Date _____

Name: _____ Date of Birth: _____ Age: _____

Nickname: _____ Sex: _____ Height: _____ Weight: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Social Security #: _____

RESPONSIBLE PARTY

Name of Person Responsible: _____

Relationship to Patient: _____ Driver's License #: _____

Birth Date: _____ Home Phone: _____ Work/Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Social Security #: _____

MEDICAL HISTORY

Have your child ever had any of the following medical problems?

Y	N	Allergies to any drugs	Y	N	Diabetes
Y	N	Any Hospital Stays	Y	N	Seizures / Epilepsy
Y	N	Any Operations	Y	N	Handicaps / Disabilities
Y	N	Heart Defects	Y	N	Cerebral Palsy
Y	N	Asthma / Lung Problems	Y	N	Developmentally Delayed
Y	N	Hepatitis / Liver problems	Y	N	Rheumatic / Scarlet Fever
Y	N	Kidney Problems	Y	N	Cancer
Y	N	Bleeding Problems	Y	N	Hearing Impairments
Y	N	Heart Murmurs	Y	N	Tuberculosis
Y	N	Latex Allergy	Y	N	Autism/Down's Syndrome

Please discuss any medical problems that the child has/had: _____

_____

_____

Child's physician: _____ Phone Number: _____

Is the child currently under the care of a physician: Yes No Date of Last Visit: _____

Please describe the child's current physical health: Excellent _____ Good _____ Poor _____

Please list all medications the child is currently taking: _____

_____

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the **strictest** of confidence and it is my responsibility to inform Dr. Amy Wong of any changes in my medical status at the earliest possible time.

Signature: _____ Date _____

Reviewed by: _____ Date _____