Welcome to our Office

MEDICAL HISTORY

Child's Name _____ Date _____

Birthdate _____

Parent's Name _____

Address _____ Home Phone _____
Zip Code

Parent's Occupation _____ Business Phone _____

Employed By _____

Whom may we thank for referring you to our office? _____

Child's Physician's Name _____

Is your child under the care of a physician now? _____

Has your child ever had:

a. Heart Trouble _____ YES NO

b. Rheumatic Fever _____ YES NO

c. Kidney Trouble _____ YES NO

d. Diabetes _____ YES NO

e. Allergic Reaction to any medications? _____ YES NO

f. Asthma _____ YES NO

g. Hepatitis _____ YES NO

Does your child have prolonged bleeding when he or she receives a scratch? YES NO

Presently, is your child taking any medication? _____ YES NO

If yes, please explain _____

Purpose of this visit _____

Child's last dental visit was: _____

Remarks: _____

Parent's Signature _____

MEDICAL UPDATES :

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	None ☐	_____		DR. _____
_____	_____	None ☐	_____		DR. _____
_____	_____	None ☐	_____		DR. _____
_____	_____	None ☐	_____		DR. _____
_____	_____	None ☐	_____		DR. _____
_____	_____	None ☐	_____		DR. _____
_____	_____	None ☐	_____		DR. _____

CHILD DENTAL AND MEDICAL HISTORIES - UPDATES

FORM 119013 N/05/02 ITEM 8101 COLWELL SYSTEMS 1.800.637.1140