

Mason Family Dentistry

Child's Dental and Health History

Child's Name _____ Birthday _____

Date of last visit to dentist _____ For what service _____

Is fluoride used at home in any form?

Child's physician _____ Address _____

Phone _____

Date of last physical examination _____ Any abnormal results?

Is child under care of physician now?

Is child receiving any medication or drugs?

Has child ever had surgery?

Has child ever been hospitalized?

Does child have any allergy to penicillin or other drugs?

Does child have any other allergies (food, dust, etc.)

Please circle below if child has any history or difficulty with any of the following:

Anemia	Chronic sinus	Hearing	Mastoid	Thyroid
Asthma	Convulsions	Heart	Measles	Tuberculosis
Bladder	Diabetes	Kidney	Mononucleosis	
Cerebral Palsy	Epilepsy	Liver	Mumps	
Chicken Pox	Fainting	Malignancies	Rheumatic fever	

Please describe any current medical treatment including drugs, pending surgery, recent injuries, other conditions, or any other information I should be aware of that we have not discussed.

The information was discussed with and given by _____

The responsible party for this child is _____

Relation to child _____