

## MEDICAL INFORMATION

Child's physician \_\_\_\_\_ Phone \_\_\_\_\_ Date of most recent visit \_\_\_\_\_

Is your child taking any medications (including over the counter) **yes / no**

If yes, please list: \_\_\_\_\_

Has your child ever been hospitalized? **yes / no**

If yes, please explain \_\_\_\_\_

Is your child allergic to any medications? **yes / no**

If yes, please list medication and nature of allergic reaction: \_\_\_\_\_

Is your child allergic to latex? **yes / no** Does your child have any other allergies? **yes / no** if yes, please list: \_\_\_\_\_

Has your child been diagnosed with any of the following? (please circle yes or no for each)

anemia	<b>yes / no</b>	cerebral palsy	<b>yes / no</b>	hearing problems	<b>yes / no</b>	kidney disease	<b>yes / no</b>	rheumatic fever	<b>yes / no</b>
asthma	<b>yes / no</b>	developmental delay	<b>yes / no</b>	heart disease	<b>yes / no</b>	liver disease / hepatitis	<b>yes / no</b>	seizures / epilepsy	<b>yes / no</b>
autism	<b>yes / no</b>	diabetes	<b>yes / no</b>	heart murmur	<b>yes / no</b>	mental retardation	<b>yes / no</b>	thyroid disorder	<b>yes / no</b>
birth defects	<b>yes / no</b>	Down's syndrome	<b>yes / no</b>	HIV positive	<b>yes / no</b>	more than 4 wks premature	<b>yes / no</b>	tuberculosis	<b>yes / no</b>
blood disease or bleeding problems	<b>yes / no</b>	fainting	<b>yes / no</b>	joint / bone problems or surgeries	<b>yes / no</b>	physical disability	<b>yes / no</b>	tumors / cancer	<b>yes / no</b>

Are there any other medical conditions concerning your child that are not listed above? **yes / no** \_\_\_\_\_

## BEHAVIORAL INFORMATION

Does your child have any behavioral or emotional problems? **yes / no** \_\_\_\_\_

Does your child have any learning disabilities? **yes / no** \_\_\_\_\_

Does your child have any sensory concerns? **yes / no** \_\_\_\_\_

Has your child ever had any experiences that may cause apprehension in the dental office? **yes / no** \_\_\_\_\_

## DENTAL INFORMATION

Do you have any concerns today about your child's teeth? **yes / no** \_\_\_\_\_

Has your child been to the dentist before? **yes / no** How long ago? \_\_\_\_\_ Were radiographs (x-rays) taken? **yes / no**

How often does your child brush? \_\_\_ **times per day** How often does your child floss? \_\_\_ **times per week**

Does your child receive help brushing and flossing? **yes / no** Does your child use a toothpaste with fluoride? **yes / no**

Does your child use a nursing bottle or sippy cup? **yes / no**

Does your child regularly eat or drink (other than water) after brushing at night? **yes / no**

Does your child have any of the following (**please circle**) thumb sucking, pacifier use, speech problems, snoring, tooth grinding?

Do you or your spouse have a high cavity rate or any serious dental or gum problems? **yes / no**

Are there any other facts about your child that you feel we should know or you would like us to consider? **yes / no**

I authorize and request the performance of dental services upon the person of the above named patient as directed by the demands of his/her dental condition at the moment of performance of such service in accordance with the judgment of Laurence A. Darrow, D.D.S., and/or Simon P. Morris, D.D.S. I also authorize and request the administration of such anesthetics or sedatives as may be deemed advisable by Laurence A. Darrow, D.D.S. and/or Simon P. Morris, D.D.S. NOTE: Any premedication /sedation will be discussed with the parent prior to the treatment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Guardian