

Medical History

Patient Name _____ Date of Birth _____

Home Address _____

Home Phone () _____

Child's Physician _____
Name Street City State Zip

Physician's Phone () _____ Date of Last Physical Exam _____

Is your child currently under the care of a physician? Yes No Please explain _____Are immunizations current? Yes No

Please list all medications your child is currently taking _____

Has your child been hospitalized for any illness, accident, or surgery? _____

Does your child have or has he/she ever had any of the following:

- | | | | |
|--|--|--|--|
| 1. Heart Trouble (Including heart murmurs, valve prosthesis) | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Rheumatic fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. High/low blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Kidney problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Autism | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Liver disease (hepatitis) | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Sinus problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. PDD | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Prolonged Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | 22. Allergy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Severe infections | <input type="checkbox"/> Yes <input type="checkbox"/> No | Specify: _____ | |
| 12. ADD/ADHD | <input type="checkbox"/> Yes <input type="checkbox"/> No | (i.e.: Medication, Seasonal, Food, NUTS Etc...) | |
| | | 23. Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Is your child allergic to or has your child had unusual reactions to:

- | | | | |
|---|--|----------------|--|
| 24. Codeine or other narcotics | <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Penicillin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Dental local anesthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Sedatives | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 26. Barbiturates | <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. Sulfa | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 27. Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28. Any other drugs or medications | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 29. Does your child have any other disease, condition, or emotional problem(s) that you would like to bring to our attention? | | | |
| Explain _____ | | | |
| _____ | | | |

Summary of medical history _____

Medical problems affecting dental treatment _____

AUTHORIZATION & RELEASE FOR THE SERVICES PROVIDED BY THE OFFICE OF STEVEN C. DEMETRIOU, D.M.D.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorized the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications. I request that my insurance company pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf.

Signature of Parent or Guardian_____
Date