Record Number _____

Medical History

Patient Name _____ Date of Birth _____

Home Address _____

Primary Phone ( ) _____

Child's Physician _____
Name Street City State Zip

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

Are there any ongoing medical issues your child is being treated for? ☐ 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)	☐ Yes ☐ No	13. Convulsions	☐ Yes ☐ No
2. Rheumatic fever	☐ Yes ☐ No	14. Pneumonia	☐ Yes ☐ No
3. High/low blood pressure	☐ Yes ☐ No	15. Tuberculosis	☐ Yes ☐ No
4. Kidney problems	☐ Yes ☐ No	16. Autism	☐ Yes ☐ No
5. Liver disease (hepatitis)	☐ Yes ☐ No	17. Sinus problems	☐ Yes ☐ No
6. Jaundice	☐ Yes ☐ No	18. Asthma	☐ Yes ☐ No
7. Diabetes	☐ Yes ☐ No	19. Fainting	☐ Yes ☐ No
8. AIDS/HIV	☐ Yes ☐ No	20. Epilepsy	☐ Yes ☐ No
9. Anemia	☐ Yes ☐ No	21. PDD	☐ Yes ☐ No
10. Prolonged Bleeding	☐ Yes ☐ No	22. Allergy	☐ Yes ☐ No
11. Severe infections	☐ Yes ☐ No	Specify:_____ (i.e.: Medication, Seasonal, Food, **NUTS** Etc…)	
12. ADD/ADHD	☐ Yes ☐ No	23. Arthritis	☐ Yes ☐ No

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

24. Codeine or other narcotics	☐ Yes ☐ No	30. Penicillin	☐ Yes ☐ No
25. Dental local anesthetics	☐ Yes ☐ No	31. Sedatives	☐ Yes ☐ No
26. Barbiturates	☐ Yes ☐ No	32. Sulfa	☐ Yes ☐ No
27. Aspirin	☐ Yes ☐ No		
28. Any other drugs or medications	☐ Yes ☐ 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. AND JASVEEN SINGH, 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