Child's Name: _____ Date of Birth: _____

MEDICAL INFORMATION

Physician's Name: _____
Physician's Address: _____
Physician's Phone #: (_____) _____Date of last exam: _____

MEDICAL HISTORY

Certain illnesses and drugs have a direct effect on the oral cavity and consequently, dental treatment. In our endeavor to render appropriate uncompromising health care it is necessary to have the following information:
DOES YOUR CHILD HAVE OR EVER HAVE HAD ANY OF THE FOLLOWING?

Anemia or blood disorders?	☐Yes ☐No	Speech disorder?	☐Yes ☐No
Abnormal or prolonged bleeding, bruises easily?	☐Yes ☐No	Learning disorder?	☐Yes ☐No
Asthma or other respiratory ailment?	☐Yes ☐No	Hearing disorder?	☐Yes ☐No
Cancer?	☐Yes ☐No	ADD, ADHD, Autism, Syndromes?	☐Yes ☐No
Congenital heart disease or heart murmur?	☐Yes ☐No	Please list: _____	
Convulsions, seizures, fainting, epilepsy?	☐Yes ☐No	Hospitalizations? _____	☐Yes ☐No
Diabetes of blood sugar problems?	☐Yes ☐No	_____	
High/ low blood pressure?	☐Yes ☐No	Surgeries? _____	☐Yes ☐No
Immunocompromised HIV/ AIDS?	☐Yes ☐No	_____	
Kidney or bladder problems?	☐Yes ☐No	Medications? _____	☐Yes ☐No
Liver problems?	☐Yes ☐No	_____	
Thyroid or other endocrine problems?	☐Yes ☐No	Allergies to Medications?	☐Yes ☐No
Rheumatic Fever or rheumatic heart disease?	☐Yes ☐No	Please list: _____	
Tuberculosis or pneumonia?	☐Yes ☐No	Allergic to Latex?	☐Yes ☐No
Childhood illnesses? _____		Other Allergies (environmental, foods, etc.)	☐Yes ☐No
_____		Please list: _____	

Does your child have any medical conditions/ problems not stated above? If so please list: _____
_____
_____

I hereby certify that the information provided on this form is true and correct in its entirety. Since the patient is a minor, signed permission from a parent or guardian is required before any necessary dental treatment can be initiated. By signing this form, I hereby grant such permission. I also acknowledge my responsibility for any professional fees incurred for dental services provided for my child. I authorized Carr Pediatric Dentistry, PA to release my child's dental records to the insurance carrier(s) provided for insurance purpose.
Parent Signature: _____Date:_____

Doctor Comments:
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