4b (CHILD'S) MEDICAL HISTORY

Current Physical Condition? ❑ Good ❑ Fair ❑ Poor
Use tobacco in any form? ❑ Yes ❑ No
Taking any over-the-counter/prescription or herbal supplement drugs? ❑ Yes ❑ No
Please List Each One _____

_____

Has your child ever been hospitalized for any reason?
❑ Yes ❑ No
Is your child physically, emotionally or mentally impaired? ❑ Yes ❑ No
Please list any other medical condition(s) that your child has had:

_____

_____

Has a doctor ever told you that your child requires antibiotics prior to dental treatments? ❑ Yes ❑ No

IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING?

Yes	No	Aspirin	Yes	No	Erythromycin	Yes	No	Penicillin
Yes	No	Codeine	Yes	No	Jewelry/Metals	Yes	No	Tetracycline
Yes	No	Dental Anesthetics	Yes	No	Latex	Yes	No	Other

Please list any other drugs/materials that you are allergic to:

_____

_____

HAS YOUR CHILD EVER HAD ANY HISTORY OF, OR CONDITIONS RELATED TO, ANY OF THE FOLLOWING?

Yes	No	Anemia	Yes	No	Hepatitis
Yes	No	Arthritis	Yes	No	HIV+/AIDS
Yes	No	Bladder	Yes	No	Immunizations
Yes	No	Bleeding Disorders	Yes	No	Kidney
Yes	No	Bones/Joints	Yes	No	Liver
Yes	No	Cancer	Yes	No	Measles
Yes	No	Cerebral Palsy	Yes	No	Mitral Valve Prolapse
Yes	No	Chicken Pox	Yes	No	Mononucleosis
Yes	No	Chronic Sinusitis	Yes	No	Mumps
Yes	No	Cold Sores/Fever Blisters	Yes	No	Pregnancy (teens)
Yes	No	Congenital Heart Defect	Yes	No	Psychiatric Problems
Yes	No	Diabetes	Yes	No	Rheumatic Fever
Yes	No	Ear Aches	Yes	No	Seizures
Yes	No	Epilepsy	Yes	No	Sickle Cell
Yes	No	Fainting	Yes	No	Thyroid
Yes	No	Growth Problems	Yes	No	Tobacco/Drug Use
Yes	No	Hearing	Yes	No	Tuberculosis
Yes	No	Heart Murmur	Yes	No	Veneral Disease
Yes	No	Heart Surgery			

Please list any other medical condition(s) that you have had:

_____

_____

5 DISCLAIMER

For 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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. The undersigned hereby authorizes Doctor, in order to make a thorough diagnosis of the patient's dental needs, to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor. I understand that the Doctor will advise me of any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) _____. I also understand that the Doctor may choose and employ such assistance as deemed fit. I further understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time that services are rendered unless financial arrangements have been previously made. I further understand that I am entitled to a 5% courtesy if payment for services is made within 24 hours. All other financial arrangements, insurance, credit cards, or time payments, are not subject to that courtesy. A 1 ½ % monthly finance charge will be applied to all accounts over 60 days past due. There will be a $25.00 service charge on all returned checks. We require 24 hours notice for cancellations. If a 24 hour notice is not given, it will be necessary to charge $30.00 for each appointment cancelled. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

_____

Signature Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

OAKVILLE DENTAL CARE

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____
Doctor's comments _____

_____