KIDS SMILE
Factoria Children Dentistry

# Patient Health History

Is the patient under the care of a physician? _____

If so, please explain_____

Physician's name_____ Phone_____

**Does the patient**:

Y____N_____ Take any medication

Please list _____

Y____N_____ Use drug, alcohol, tobacco

Y____N_____ Need to take medication before dental procedure due to heart condition

Y____N_____ Allergic to medication/ food / latex/ metal; if so, please specify

_____

Y____N_____ Play a wind instrument

Y____N_____ Mouth breathe or have trouble breathing through nose

**Please check if the patient has had any of the following**:

_____ ADHD/ADD
_____ Anemia
_____ Asthma
_____ Abnormal Bleeding
_____ AIDS/HIV positive
_____ Birth defects
_____ Bladder problems
_____ Bronchitis
_____ Cancer
_____ Chicken pox
_____ Cerebral palsy
_____ Diabetes
_____ Epilepsy/Seizures
_____ Heart problems
_____ Heart murmur
_____ Hearing problems
_____ Hepatitis
_____ Jaundice
_____ Joint replacement
_____ Learning disabilities
_____ Measles
_____ Mononucleosis
_____ Mumps
_____ Kidney problems
_____ Physical treatment
_____ Rheumatic fever
_____ Tuberculosis
_____ Sinus trouble
_____ Liver disease

Please explain any categories that are checked above

_____

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# Authorization

I certify that this information is true and accurate. I will notify Kids Smile FCD of any changes in this medical history. I agree to allow the doctor to discuss and share this information with whomever she deems necessary.

Parent/Guardian signature _____ Date _____

In the case that I have insurance coverage, I release all insurance payments from insurance company, for the services rendered, to the doctor. I understand I am responsible for the balance not cover by my insurance.

Parent/Guardian signature _____ Date _____

Dr's signature _____ Date _____