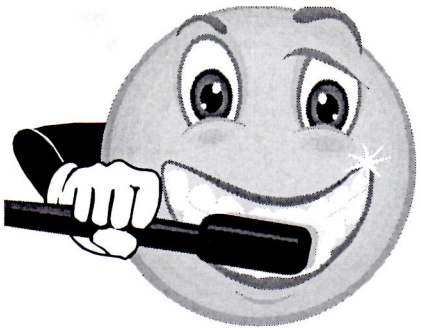

Pediatric Health History

Medical Health History

General health :(circle one)
excellent good fair poor
Child's physician:

Physician phone#
date of last physical exam:
Is the child being treated at this time?
(if yes, please explain)

Does the child have or ever had?

Cardiac/heart disorders.....yes no
Asthma.....yes no
Rheumatic fever.....yes no
Liver disease.....yes no
Anemia..... yes no
Epilepsy/convulsions.....yes no
High cholesterol.....yes no
Arthritis..... yes no
Diabetes.....yes no
Hepatitis.....yes no
Tuberculosis.....yes no
Kidney disease.....yes no
Endocrine disorders.....yes no
Other_____
Is child allergic to? (please check)
penicillin __ codeine___
novocaine ___ latex ___
Is the child taking any medications?
If so, what?_____

Does the child have any emotional problems?
If so, please describe_____

_____

Are there any other health concerns we should be aware of?_____If so, please describe:

Madison Dental Associates

last name_____first_____m____
address_____
state_____zip code_____

parent/legal guardian_____

phone#_____cell#_____
work phone#_____

Dental Health History

How long since your child's last dental exam?

What concerns you most about your child's dental health?_____
_____

Does the child ever have dental pain? If so, when?_____
did the child ever have a negative dental experience? If so, please explain:_____
_____
Has the child ever had any injuries to the face?
If so, please check: mouth___ teeth___
face ___ jaw ___
Does the child have speech problems?

Is the child a mouth breather?
while awake?_____while asleep?____

Has your child had teeth removed?
Has your child had orthodontic treatment?
How often does your child brush?
How often does your child floss?
Has your child had any fluoride treatment?

I verify the above and give consent for treatment

x_____date / /