

| HEALTH HISTORY | YES | NO | COMMENTS |
|---------------------------|------------|-----------|-----------------|
| MEDICATIONS | | | |
| DRUG ALLERGIES | | | |
| ALLERGIES | | | |
| HOSPITALIZATIONS | | | |
| SURGERY | | | |
| UP-TO-DATE IMMUNIZATIONS | | | |
| HEART CONDITION | | | |
| LUNG PROBLEMS | | | |
| ASTHMA | | | |
| AIDS | | | |
| ANEMIA/SICKLE CELL ANEMIA | | | |
| BEHAVIORAL PROBLEMS | | | |
| BLEEDING DISORDERS | | | |
| BLOOD TRANSFUSION | | | |
| CEREBRAL PALSY | | | |
| CHICKEN POX | | | |
| DIABETES | | | |
| EMOTIONAL DISORDER | | | |
| EPILEPSY | | | |
| HEPATITIS | | | |
| HEARING/SPEECH PROBLEMS | | | |
| KIDNEY PROBLEMS | | | |
| LIVER PROBLEMS | | | |
| MENTAL RETARDATION | | | |
| MUMPS/MEASLES | | | |
| MONONUCLEOSIS | | | |
| PREGNANCY | | | |
| RHEUMATIC FEVER | | | |
| THYROID DISORDERS | | | |
| TUBERCULOSIS | | | |
| VISION PROBLEMS | | | |
| OTHER | | | |

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment:

Because your child is a minor, it is necessary that signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment is performed.

The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until canceled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment should named responsible party fail or insurance benefit be denied.

Date _____

Signed _____