Sadler Health Center

(Office use Account #_____)

Dental Department Child Health History

Date: _____

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Relationship to Patient: _____

Medical Doctor (Name, address, phone number): _____

Date of last physical or well child visit: _____

Please list any medications (prescription or over the counter), vitamins, or supplements your child is taking:

Please list all allergies and reactions your child has:

Has your child been hospitalized or has had any other serious illness? If yes, please list:

DOES YOUR CHILD HAVE OR HAS HAD THE FOLLOWING CONDITIONS? Check YES, NO, DON'T KNOW

	YES	NO	DK		YES	NO	DK
Epilepsy/Seizures	☐	☐	☐	Immune Disease	☐	☐	☐
Heart Problems	☐	☐	☐	Kidney Problems	☐	☐	☐
Pace Maker	☐	☐	☐	Liver Problems	☐	☐	☐
Artificial Heart Valve	☐	☐	☐	Diabetes	☐	☐	☐
Rheumatic Fever	☐	☐	☐	Acid Reflux	☐	☐	☐
Anemia	☐	☐	☐	Behavioral Problems	☐	☐	☐
Blood Disorders	☐	☐	☐	Developmental Problems	☐	☐	☐
Lung Problems	☐	☐	☐	Genetic Disease	☐	☐	☐
Asthma	☐	☐	☐	Neurological Problems	☐	☐	☐
Muscular Disease	☐	☐	☐				

Please list any disease, condition, or problem not listed above:

Dental History

Who was your child's previous dentist? _____

When was the last dental exam, xrays, and cleaning? _____

Has your child ever had any serious complications with dental treatment?..... Yes ☐ No ☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or missing 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.

_____ _____

Patient/Guardian Signature Date

_____ _____

Dentist/Hygienist Signature Date

Updated 7/2019