

4. Is your child allergic to antibiotics or other drugs?-----YES/NO
What is the name of medication(s)? _____
5. Is your child allergic to or sensitive to latex?-----YES/NO
6. Does your child have any other allergies?----- YES/NO
Please describe: _____
7. Has your child had any recent serious illness or hospitalization?-----YES/NO
When _____ What _____
8. Is your child suspected to nervous disorders?-----YES/NO
Fainting? Seizures? Dizziness? Behavioral/Learning problem? Other?
Please describe: _____
9. Does your child have frequent headaches?-----YES/NO
10. Does your child suffer from high/low blood pressure?-----YES/NO
11. Has your child have a history of (Circle appropriate responses) diabetes, **heart trouble**, Valvular replacements, pacemaker, **asthma**, kidney infection, **rheumatic fever**, artificial (prosthetic joints), epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, **infections**, speech impairments, hearing loss, pregnancy, developmental delays.
12. Other, please explain _____

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform the office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of parent/guardian

Date

FOR DENTIST USE ONLY

Comments:

Signature of Dentist

Date