MEDICAL HISTORY

Patient Name:_____ Date: _____ D.O.B._____.
Child's Physician:_____ Physician Phone:_____.
Has your child every had problems with any of the following? (Please Circle)

Heart Disease	Y	N	Allergies	Y	N	AIDS	Y	N
Heart Murmur	Y	N	Hearing	Y	N	Bones	Y	N
Convulsions	Y	N	Hepatitis	Y	N	Sight	Y	N
Liver/GI Problems			Y	N	Epilepsy/Seizures		Y	N
Asthma/Breathing			Y	N	Rheumatic Fever		Y	N
Endocrine system/Diabetes			Y	N	Blood Dycrasias		Y	N
Kidney Disease			Y	N	Significant Injuries		Y	N
History of Abnormal Bleeding			Y	N	Frequent Infections		Y	N

Cancer/Tumor Y N_____
Drug Allergies Y N_____.
Adverse Drug Reactions Y N_____.
Congenital Birth Defects Y N_____.
Recurrent/Frequent Headaches Y N_____.
Mental/Physical Delays Y N_____.
Behavioral/Learning Problems Y N_____.
History of Blood Transfusion/Date Y N_____.
Hospitalization/Date Y N_____.
Surgeries/Date Y N_____.
Current Medications Y N_____.
_____.
What Best Describes your child's social development(Personality/temperament, eg. Shy/reserved)?_____.
Is there anything else we should know about your child?_____.
_____.
_____.

CONSENT FOR DENTAL TREATMENT & FINANCIAL RESPONSIBILITY:

I request and authorize Dr. Maurice to exam, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Maurice to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Maurice will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Legal Parent or Guardian_____Date:_____.
Dentist_____Witness:_____.