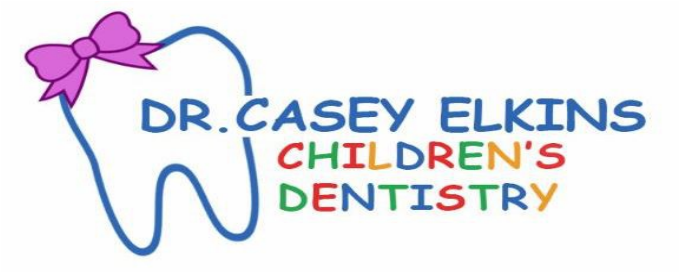

MEDICAL HISTORY

PATIENT NAME: _____ NICKNAME: _____

ETHNICITY: _____RACE:_____PRIMARY LANGUAGE SPOKEN:_____

DOB: _____ AGE: _____ SEX: _____ INSURED SSN#: _____

SCHOOL: _____ CHILD'S GRADE: _____

HOME ADDRESS:_____

CITY, STATE, ZIP: _____

PHONE NUMBER:_____EMAIL:_____

HOW DID YOU HEAR ABOUT OUR OFFICE:_____

Does your child have any major health problems? No_____ Yes: _____

Explain: _____

Has your child been hospitalized? Yes _____ No _____

Have you ever been told that your child has heart murmur? Yes _____ No _____

If yes, please explain? _____

If yes, is an antibiotic prophylaxis needed? (Explain) _____

Is your child currently being treated by a physician? Yes _____ No _____

If yes, please explain _____

What medications is your child currently taking? _____

Does your child suffer from any allergies? Yes _____ No _____

If yes, please explain _____

Does your child have Asthma? Yes _____ No _____

If yes, is it controlled with meds? (Explain) _____

Last visit to ER? _____

Has your child ever experienced an unfavorable reaction to drugs, including antibiotics, or local anesthetic? Yes _____ No _____

If yes, please explain _____

Does your child have developmental or behavioral problems? Yes _____ No _____

If yes, please explain? _____

Child's Name _____

Has your child had history or difficulty with any of the following? (Please Circle)

ADD/ADHD Diabetes Malignancies/Cancer Bleeding Disorders

Autism Spectrum Ears/Hearing Seizures/Epilepsy Heart

Sensory Integration Issues Kidneys Depression

Thyroid Liver/Hepatitis Other:_____

Child's Physician _____ Phone #_____

Last visit to the dentist: Date: _____ Dentist: _____

Routine Cleaning Emergency Visit Treatment

What was your child's behavioral response to past dental or medical care? _____

Any concerns about your child's teeth? _____

Any injury to the teeth, mouth or head? _____

Any history of the following? (Circle)

Headaches TMJ/Joint Problems Swelling Pain Teeth Grinding

Does your child have any Habits, Past or Current?

Thumb / Finger sucking Bottle Pacifier Lip Biting Nail Biting

Does your child brush daily? _____

Do you assist your child with brushing? _____

Do you assist your child with flossing? _____

Does your child take fluoride in any form? _____

What is your child's attitude toward dentistry? _____

Is there any other information that you would like us to know about your child or have specific concerns about? _____

To the best of my knowledge, the questions on this form have been accurately answered, I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status, I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian _____ Date: _____

Dr. Cassandra "Casey" Elkins

Office: (210) 268-0414 Fax: (210)694-5066

****Several Locations to serve you****