

# Child's Medical History Form:

Please fill out and sign at the bottom.

Child's name \_\_\_\_\_  
Nickname \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
SS# \_\_\_\_\_ age \_\_\_\_\_  
Special interests \_\_\_\_\_  
\_\_\_\_\_  
Home Address \_\_\_\_\_  
\_\_\_\_\_  
Home Phone \_\_\_\_\_  
Last dental visit \_\_\_\_\_  
Child's physician \_\_\_\_\_  
Physician,s # \_\_\_\_\_

Your name \_\_\_\_\_  
DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_  
Relationship to child \_\_\_\_\_  
Home address \_\_\_\_\_  
\_\_\_\_\_  
Hm ph# \_\_\_\_\_ Wk ph# \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Other contact ph#s \_\_\_\_\_  
\_\_\_\_\_  
Referred by \_\_\_\_\_

Does your child have any dental problems _____ _____ Please rate your child's dental health _____ Does your child brush their teeth daily _____ Please rate your child's medical health _____ List any drug allergies _____ _____ List current medications your child is taking _____ _____ _____	<b>Has your child ever had any of the following:</b> Y / N – Any Hospital Stays Y / N – Any Operations Y / N – Bleeding Problems Y / N – Cancer Y / N – Convulsions / Epilepsy Y / N – Diabetes Y / N – Hearing Impairment Y / N – Heart Murmur Y / N – Heart Problem of Any Kind Y / N – Hemophilia Y / N – HIV+ / AIDS Y / N – Hyperactive Y / N – Rheumatic Fever / Scarlet Fever Other _____ _____
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This information is true to the best of my knowledge:

I authorize Dr. Leonard Fu to perform the necessary dental services my child may need.

Signed \_\_\_\_\_ parent/guardian date \_\_\_\_\_

Emergency Contact \_\_\_\_\_ relationship \_\_\_\_\_ phone \_\_\_\_\_