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_____ _____ _____ _____	Has your child ever had any of the following: 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_____ _____

This information is true to the best of my knowledge:
I authorize Dr Johnson to perform the necessary dental services my child may need.

Signed_____ parent/guardian date_____

Emergency Contact_____ relationship_____ phone_____

David A Johnson, DDS 505 South Drive #9, Mountain View, CA 94040 650-967-1075