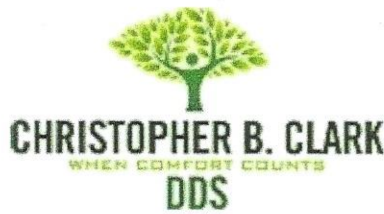

Health History- Minor/Child

Child's Name ____________________ Preferred Name __________ Date of Birth ______________
Parent/Guardian Name __________________ Phone ____________ Email ___________________
Address ____

Whom may we thank for referring you? _______________ Is this your child's first visit to a dentist? _____
Do you have specific concerns? ____

Do any of the following conditions apply (please check):

___ Anemia	___ Seizures/Convulsions	___ Autism Spectrum Disorder
___ Asthma	___ Diabetes	___ Special Needs
___ Kidney Disease	___ HIV Positive	___ ADHD
___ Liver Disease	___ Bleeding Disorder	___ Speech Impairment
___ Mitral Valve Prolapse	___ Rheumatic Fever	___ Hearing Impairment
___ Tuberculosis		

Allergies (circle any that apply)

Aspirin NSAIDS Penicillin Codeine Local Anesthetics Metals No Known Allergies

Other Allergies: ____

Dental History

___ Cavities	___ Orthodontic Treatment	___ Broken Teeth
___ Toothache	___ Extractions	___ Gum Infection
___ Pain		___ Unpleasant Experience at Dentist

Additional information that you could share so we can provide your child with the best possible experience:

____

____

____ I understand that I am financially responsible for all changes whether or not paid by insurance
____ I authorize Dr. Clark and his staff to perform all necessary dental services
____ I authorize Dr. Clark to release and receive information to and from my physicians, and other health care providers
____ I authorize the use of below signature on all insurance claims
____ I authorize the insurance company to pay Dr. Clark all insurance benefits otherwise payable to me for services performed
____ 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 health. It is my responsibility to inform the dental office of any medical changes

Date____________________ **Signature**_______________________________