Macomb
children's dentistry

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Child's Name: _____ Date of birth: _____

Name of child's pediatrician: _____ Phone number of pediatrician_____

Medical History (any Y answers - please explain)

Is your child under medical treatment at this time? Y N _____

Has your child ever had a major operation? Y N _____

Has your child ever had an adverse reaction to medication? Y N _____

Does your child have an allergy to any medication? Y N _____

Is your child currently taking any medication(s)? Y N _____

Has your child been diagnosed with any of the following?

Heart Murmur	Y N	_____
Respiratory Disease/ Asthma	Y N	_____
Mental or Learning Delay	Y N	_____
Heart Ailment	Y N	_____
Blood Disease or Anemia	Y N	_____
Kidney or Liver Disease	Y N	_____

Are there any other Medical concerns that the dentist should be aware of?
Explain: _____

dental History (any Y answers - please explain)

Does your child have any dental complaints at this time? Y N _____

Has your child had any previous dental trauma? Y N _____

Is there anything about your child's teeth you are not happy with? Y N _____

Are there any other dental concerns that the dentist should be aware of?
Explain: _____

Parent or Guardian Signature:_____ Date: _____