MEDICAL HEALTH HISTORY

Name:____ □ **M** □ **F Goes By:**:_______________
First Last
Age: _______ **DOB**: _____________________ **SSN**: ________________________

Child's Medical Doctor: _______________________________ **Telephone#**: _____________
Is this your child's 1st dental visit: □ YES □ NO **Date of dental check up**: _____________
Does your child have any LATEX allergies: □ YES □ NO Child's current weight: ________________
Emergency contact
Name _______________________ **Relationship:**_____________ **Phone #:**_______________

Please CHECK if your child has ever been treated for any of the following:

Y□ N□ ADD/ADHD
Y□ N□ Autism/Aspergers
Y□ N□ Physical delays
Y□ N□ Mental delays Diabetes
Y□ N□ Cerebral palsy Hepatitis (Type) ____
Y□ N□ Speech/hearing
Y□ N□ Seizures/convulsions
Y□ N□ Recurring headaches
Y□ N□ AIDS/HIV
Y□ N□ Hepatitis (Type) ___
Y□ N□ Bleeding/transfusions
Y□ N□ Heart disease
Y□ N□ Heart murmur
Y□ N□ Anemia
Y□ N□ Liver/GI disease
Y□ N□ Pregnancy
Y□ N□ Asthma
Y□ N□ Cancer/tumors
Y□ N□ Cleft lip/palate
Y□ N□ Rheumatic fever
Y□ N□ Diabetes
Y□ N□ Artificial joint or valve
Y□ N□ Stomach problems/ulcer
Y□ N□ Kidney disease

Please explain any YES items checked above: ____
____
Is your child allergic to anything? □ YES □ NO If yes, ____
Has your child ever been hospitalized? □ YES □ NO If yes, _____________________________________
Please list any medication(s) your child is taking: ____
Does your child have any of the following habits?
□ **Thumb/finger/lip sucking** □ **Pacifier** □ **Tongue thrusting** □ **Grinding**
When was your child's last dental appt: ___________________ last dental xrays:____________________
Has your child ever experienced any unfavorable reaction from previous dental care? □ YES □ NO
If so, please explain: ____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize **Dr. Bustillo/Featherston** to release my information including diagnosis and the records to any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Consent:

I consent to the dental x-rays, diagnostic procedures and treatment by the dentist necessary for proper dental care. By signing this I authorize communications for my health information via unsecured email & I understand that I have the right to revoke the authorization at any time after written notice from me

____ ________________________
Signature of Patient, Parent, Guardian or Personal Representative ***Date***

____ ________________________
Please print name of Patient, Parent, Guardian or Personal Representative Date