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## Medical History Review

Child's name \_\_\_\_\_ Age \_\_\_\_\_

Parent's name \_\_\_\_\_

**If you would like to confirm appointments by email or text message, please let us know!**

**Email:** \_\_\_\_\_ **Mobile:** (\_\_\_\_) \_\_\_\_\_

- Has your contact information changed within the last 6 months? **Yes / No**
- Has your employment or your insurance coverage changed within the last 6 months? **Yes / No**

**If you answered yes to the above, please update your information below.**

Address \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

New Insurance information \_\_\_\_\_

**Please provide our team with an updated health history.**

1) Has your child seen a medical doctor for anything unusual or serious within the last six months? **Yes / No**  
Explain \_\_\_\_\_

2) Is your child currently under the care and treatment of a medical doctor for any sickness? **Yes / No**  
Explain \_\_\_\_\_

3) Is your child currently taking any medication? **Yes / No**  
Explain \_\_\_\_\_

4) Does your child have any type of allergies, heart problems, blood problem, or seizure disorder? **Yes / No**  
Explain \_\_\_\_\_

Questions you may have: \_\_\_\_\_

I am the parent, guardian or personal representative of the above named child and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the dentist, whether or not I am present when the treatment is rendered.

Date \_\_\_\_\_ Signature \_\_\_\_\_  
Relationship to patient \_\_\_\_\_