

Medical History Review

Child's name _____ Age _____

Parent's name _____

- 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 _____

Your child will be seen by Dr. Edwards. 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 prescribed by a dentist or medical doctor? **Yes / No** Explain _____

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

Questions you have for Dr. Edwards: _____

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 _____

FOR OFFICE USE ONLY BELOW THIS LINE

Present medical status _____ Positive / Negative

Dr.'s initials _____