Medical History Review

Age___________

Child's Name ____
Parent's Name ____
Email ____
Address ____
City __________________________________State _________ Zip ___________
Home Phone________________________ Cell Phone ______________________
Guardian Employer _____________________Phone _______________________

Current Insurance____

Please answer the following questions for us by circling the appropriate answer

1. Has your child seen a medical doctor for anything unusual or serious within the last six months? ___________________________________YES/ NO

2. Is your child currently under the care and treatment of a medical doctor for any sickness? ____YES/NO

3. Is your child currently taking any medication prescribed by a dentist or medical doctor? ____YES/NO

4. Does your child have any type of seizure disorder, heart problem, blood problem, or allergy? ____YES/NO

5. Questions you have for the Doctor? _________________________________
____
____
____

Date _______________ Guardian Signature ______________________________

Relationship to patient ____

FOR OFFICE USE BELOW THIS LINE

- -

Doctor's Initials _________

OH: G F P

Needs to improve:

_____

_____

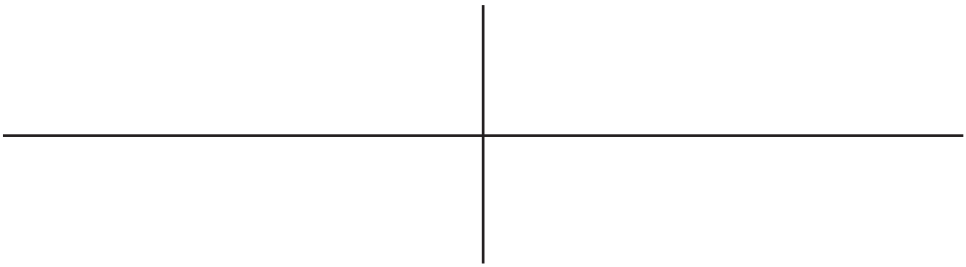
_____

_____

X-rays: BWX Pano No

Decay: Yes No Watch

Tx: Yes No



Ref: Ortho O.S. Endo