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 525 High School Road NW Bainbridge Island, WA 98110
 (206) 842-4794

DATE: _____

CHILD'S NAME: _____ SCHOOL: _____ BIRTH DATE: _____

ADDRESS: _____

PHONE #: _____

FATHER'S NAME: _____ S.S.#: _____ BIRTH DATE: _____

EMPLOYED BY: _____ BUS. PHONE: _____

INSURANCE: _____ GROUP #: _____

MOTHER'S NAME: _____ S.S.#: _____ BIRTH DATE: _____

EMPLOYED BY: _____ BUS. PHONE #: _____

INSURANCE: _____ GROUP #: _____

REFERRED BY: _____

MEDICAL HISTORY

IS CHILD IN GOOD HEALTH?.....YES NO

• HAS THERE BEEN ANY CHANGE IN THE CHILD'S HEALTH THE PAST YEAR?.....YES NO

• CHILD'S LAST PHYSICAL EXAMINATION WAS ON _____

• IS CHILD NOW UNDER THE CARE OF A PHYSICIAN?.....YES NO

• NAME OF CHILD'S PHYSICIAN _____

• HAS THE CHILD HAD ANY SERIOUS ILLNESS OR OPERATION?.....YES NO

HAS THE CHILD BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE PAST 5 YEAR?.....YES NO

• IF SO, WHAT FOR? _____

HAS THE CHILD HAD SURGEY, X-RAY OR DRUG TREATMENT FOR TUMOR GROWTH OR OTHER CONDITION?.....YES NO

• IS THE CHILD TAKING ANY DRUGS OR MEDICATION?.....YES NO

• IF SO, WHAT? _____

• IS THE CHILD TAKING ANY OF THE FOLLOWING:

- | | | |
|--|-----|----|
| 1. ANTICOAGULANTS (BLOOD THINNERS)..... | YES | NO |
| 2. ANTIBOTICS OR SULFA DRUGS..... | YES | NO |
| 3. MEDICINES FOR HIGH BLOOD PRESSURE..... | YES | NO |
| 4. CORTISONE (STERIODS)..... | YES | NO |
| 5. TRANQUILIZERS..... | YES | NO |
| 6. ANTIHISTAMINES..... | YES | NO |
| 7. ASPRIN..... | YES | NO |
| 8. INSULIN, TOLBUTAMID (ORINASE), OR SIMILAR DRUG..... | YES | NO |
| 9. DIGITALIS OR DRUGS FOR HEART TROUBLE..... | YES | NO |
| 10. NITROGLYCERIN..... | YES | NO |
| 11. OTHER _____ | | |

• DOES CHILD HAVE OR HAS HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

1. DAMAGED HEART VALVES OR ARTIFICIAL HEART VALVES, HEART MURMUR.....	YES	NO
2. CONGENITAL HEART LESIONS.....	YES	NO
3. HEART TROUBLE, HEART ATTACK.....	YES	NO
4. RHEUMATIC FEVER.....	YES	NO
5. HIGH BLOOD PRESSURE.....	YES	NO
6. ALLERGIES.....	YES	NO
7. SINUS TROUBLE.....	YES	NO
8. RESPIRATORY PROBLEMS (ASTHMA, EMPHYSEMA, CHRONIC BRONCHITIS, TB).....	YES	NO
9. SEIZURES.....	YES	NO
10. DIABETES.....	YES	NO
11. HEPATITIS, JAUNDICE, OR LIVER DISEASE.....	YES	NO
12. ARTHRITIS, INFLAMMATORY RHEUMATISM.....	YES	NO
13. ARTIFICIAL JOINTS.....	YES	NO
14. STOMACH ULCERS.....	YES	NO
15. MULTIPLE SCLERIOSIS.....	YES	NO
16. LOW BLOOD PRESSURE.....	YES	NO
17. EPILEPSY.....	YES	NO
18. PSYCHIATRIC PROBLEMS / MEDICATIONS.....	YES	NO
19. CANCER.....	YES	NO
20. AIDS OR OTHER IMMUNOSUPPRESSIVE DISORDERS.....	YES	NO
21. ABNORMALLY LONG BLEEDING TIME OR BRUISE EASILY.....	YES	NO
22. BLOOD TRANSFUSION.....	YES	NO
23. BLOOD DISORDERS, ANEMIA.....	YES	NO

• IS CHILD ALLERGIC OR HAS CHILD REACTED ADVERSELY TO:

1. LOCAL ANESTHETICS (NOVACAINE).....	YES	NO
2. PENICILLIN OR OTHER ANTIBIOTICS.....	YES	NO
3. SULFA DRUGS.....	YES	NO
4. BARBITURATES, SEDATIVES, OR SLEEPING PILLS.....	YES	NO
5. ASPRIN.....	YES	NO
6. IODINE.....	YES	NO
7. CODEINE OR OTHER NARCOTICS.....	YES	NO
8. SULFITES.....	YES	NO
9. OTHER _____		

• DOES CHILD HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT? IF SO, EXPLAIN:

• WHEN WAS CHILD LAST SEEN BY A DENTIST? _____

• NAME OF PREVIOUS DENTIST _____

• HAS CHILD HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT? IF SO, EXPLAIN _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENTS OR EXAMINATIONS RENDERED, TO MY INSURANCE COMPANY OR COMPANIES. THIS RELEASE IS SOLELY FOR THE PURPOSE OF FACILITATING THE BILLING AND REIMBURSEMENT, DIRECTLY TO THE DOCTOR, OF INSURANCE BENEFITS UNDER WHICH I AM ENTITLED. I WILL NOT HOLD MY DENTIST, OR ANY OTHER MEMBER OF HIS/HER STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGNATURE _____