Time 2:27 PM

Scott Erler DDS., P.C.

Date 9/24/2014

Child Medical History 0 - 10

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Has your child been under a physician's care now?	◯ Yes ◯ No	If yes
What is the name of their Primary Physician?	◯ Yes ◯ No	
Has your child been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Has your child ever had a serious head or neck	◯ Yes ◯ No	If yes
Is your child taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Is your child on a special diet?	◯ Yes ◯ No	If yes
What is your childs weight?		

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Metal ☐ Latex

☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Does your child have, or have had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No
Rheumatic Fever	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Hives or Rash	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No
Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No
Lung Disease	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No
Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No	Digestive Disorders	◯ Yes ◯ No
Hearing Impairment	◯ Yes ◯ No						

Does yourchild have any serious illness not listed above? ◯ Yes ◯ No If yes

Has your child been to a dentist before?	◯ Yes ◯ No	
Have you experienced problems with previous dental work?	◯ Yes ◯ No	If yes
Has your child taken fluoridated supplements?	◯ Yes ◯ No	If yes
Has your child ever had any jaw joint pain?	◯ Yes ◯ No	If yes
Does your child brush and floss his/her teeth daily?	◯ Yes ◯ No	If yes
Does your child require antibotics before dental	◯ Yes ◯ No	If yes
Has your child had any injuries to the mouth, teeth or head?	◯ Yes ◯ No	If yes
Does your child drink sodas?	◯ Yes ◯ No	

Did/Does your child have any of the following Habits:

Nursing Bottle Habits	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No	Thumb/Finger Suckiing	◯ Yes ◯ No
Clenching/Grinding	◯ Yes ◯ No	Lip Suckiing/Biting	◯ Yes ◯ No	Mouth Breather	◯ Yes ◯ No
Nail Biting	◯ Yes ◯ No	Orthodontic Treatment	◯ Yes ◯ No		

I understand that the information that I have given is correct and to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changers in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

I AUTHORIZE ASSIGNMENT OF BENEFIT PAYMENTS TO DR. SCOTT ERLER, DDS, PC. I AUTHORIZE THE RELEASE OF ANY DENTAL INFORMATION NEEDED TO PROCESS CLAIMS.

Signature of Patient, Parent or Guardian:

X Date: