Douglas J Kardynal, D.D.S.

We Cater To Cowards

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Child Health/Dental History Form

Patient Name

_____

Last Name First Name Preferred Name

Address_____City_____State_____Zip_____

Sex: ___M ___F Age_____ Birthdate_____

Who is responsible for this account? _____ Relationship to Patient_____

Email address_____ Cell Phone_____ Home Phone_____

Name of Dental Insurance Company_____ Group Number_____ Insured ID _____

In case of emergency, who should be notified? _____Phone_____

Who may we thank for referring you? _____

Medical History

Physician's Name: _____ Date of Last Physical: _____

Do any of the following conditions apply to your child? (Check all that apply)

___ Anemia	___ Cancer	___ Epilepsy	___ Arthritis
___ Cerebral Palsy	___ Fainting	___ Asthma	___ Chicken Pox
___ Growth Problems	___ Bladder Problems	___ Chronic Sinusitis	___ Hearing Loss
___ Bleeding Disorder	___ Diabetes	___ Heart Murmur/Disease	___ Artificial Bones/Joint
___ Earaches	___Hepatitis	___ HIV+/AIDS	___ Immunizations
___ Kidney Disease	___ Venereal Disease	___ Mumps	___ Liver Disease
___ Measles	___ Mononucleosis	___ Thyroid Problems	___ Rheumatic Fever
___ Seizures	___ Sickle Cell	___ Tonsillitis	___ Tuberculosis

Does your child take fluoride supplements? _____ Is fluoride toothpaste used? _____

Does your child have any drug allergies or ever had an adverse reaction to any medication? _____ If so, what?

_____

Has your child ever responded adversely to medical or dental treatment?

_____

Is your child taking any medications at this time? ____If so, what? _____

Is your child under the care of a physician? ____Yes, ____ No For what conditions? _____

(Teenage girl) Do you suspect that your daughter is pregnant? ____Yes, ____No

Is there anything else we should know about your child's medical history?

_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I, as parent/guardian of my child, have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. The above information is accurate and complete to the best of my knowledge and is only for use in my child's treatment, billing and processing of insurance for benefits which are entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Parent/Guardian Signature_____ Date _____

Print Parent/Guardian Name _____