## MEDICAL HISTORY

**Y N Is your child under the care of a physician? Name of physician _____**

**Y N Is your child allergic to any medications?**

**_____**

**Y N Has your child had any serious illness?**

**Y N Been hospitalized or had any surgery?**

**Y N Has your child had a history of the following (CIRCLE ALL THAT APPLY): heart trouble, murmur or surgery?**

**Y N Do you see a doctor for this heart condition? Pre-med needed? Y N**

**Y N ADD / ADHD _____**

**Y N Asthma, TB or other lung problems**

**Y N Autism**

**Y N Latex or rubber allergy**

**Y N Sickle cell anemia or blood disorder**

**Y N Hepatitis or liver problems**

**Y N Diabetes**

**Y N Cancer, tumor or leukemia**

**Y N Epilepsy or other seizures**

**Y N Cerebral Palsy or developmental delay**

**Y N Has your child had a history of the following (CIRCLE ALL THAT APPLY): Hearing, vision or speech problems**

**Y N Emotional or psychological problems**

**Y N HIV or AIDS**

**Y N Any other medical problems/issues?**

*******ANY yes answers….please explain further**

**_____**

**_____**

**_____**

**Please list any medications your child is taking:**

**_____**

**_____**

**_____**

**I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the office of any changes.**

**I authorize Dr. Joel E. Whitt and/or such associates or assistants as he may designate, to perform those procedures as may be deemed necessary or advisable to maintain my child's dental health (or minor in my care), including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.**

**I understand that the administration of local anesthetic may cause an untoward reaction or side effects which may include but are not limited to, bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.**

**I do understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or possibly painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.**

**I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me as necessary and I have been given the opportunity to ask questions.**

**Parent Signature _____**

**Date _____**

**Child's Name _____**