Sadler Health Center Corporation
Health and Education for Everyone

(Office use Account #___________)

Dental Department Child Health History

Date: ________________________

Patient Name: ____ Date of Birth: __________________

Parent/Guardian Name: ___________________________ Relationship to Patient: _________________

Medical Doctor (Name, address, phone number): ____

Date of last physical or well child visit: _____________________

Please list any medications (prescription or over the counter), vitamins, or supplements your child is taking:

Please list all allergies and reactions your child has:

Has your child been hospitalized or has had any other serious illness? If yes, please list:

DOES YOUR CHILD HAVE OR HAS HAD THE FOLLOWING CONDITIONS? Check YES, NO, DON'T KNOW

Condition	YES	NO	DK
Epilepsy/Seizures	☐	☐	☐
Heart Problems	☐	☐	☐
Pace Maker	☐	☐	☐
Artificial Heart Valve	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Anemia	☐	☐	☐
Blood Disorders	☐	☐	☐
Lung Problems	☐	☐	☐
Asthma	☐	☐	☐
Muscular Disease	☐	☐	☐
Immune Disease	☐	☐	☐
Kidney Problems	☐	☐	☐
Liver Problems	☐	☐	☐
Diabetes	☐	☐	☐
Acid Reflux	☐	☐	☐
Behavioral Problems	☐	☐	☐
Developmental Problems	☐	☐	☐
Genetic Disease	☐	☐	☐
Neurological Problems	☐	☐	☐

Please list any disease, condition, or problem not listed above:

Dental History

Who was your child's previous dentist? ____

When was the last dental exam, xrays, and cleaning? ____

Has your child ever had any serious complications with dental treatment?.......................... Yes ☐ No ☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or missing information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____ _________________________________

Patient/Guardian Signature Date

____ _________________________________

Dentist/Hygienist Signature Date