	YES	NO
4. Asthma or Hay Fever	Yes	No
5. Diabetes or blood sugar problems	Yes	No
6. Any prolonged bleeding or bruises easily	Yes	No
7. Swollen joints	Yes	No
8. Kidney or bladder problems	Yes	No
9. Anemia or Blood Disorders	Yes	No
10. Tuberculosis or Pneumonia	Yes	No
11. Liver problems: Jaundice or Hepatitis	Yes	No
12. Glandular or Hormonal Problems	Yes	No
13. Accidents or severe infection	Yes	No
14. Convulsions, Seizures, Fainting or Epilepsy	Yes	No
15. High/Low Blood Pressure	Yes	No
16. Speech, Learning, or Hearing Problems	Yes	No
17. Childhood Illness	Yes	No
18. Immunizations	Yes	No

Any Other, Please explain

_____

_____

Summary (Doctor's Use Only)

Please describe any current medical treatment including drugs, pending surgeries, recent injuries or any other information the Dentist should be aware of not covered above

_____

_____

History Taken From _____

Recorded By _____ Date _____

Subsequent histories by (Relationship) _____

Name (Relationship) _____ Recorded By _____

Date _____

Name (Relationship) _____ Recorded By _____

Date _____

I HEREBY CERTIFY THE FOREGOING INFORMATION CORRECT AND TRUE. BECAUSE _____ IS A MINOR, IT BECOMES NECESSARY THAT A SIGNED PERMISSION IS OBTAINED FROM A GUARDIAN OR PARENT BEFORE ANY AND/OR ALL NECESSARY DENTAL TREATMENT CAN BE COMMENCED. AUTHORIZATION IS HEREBY GRANTED AS SUCH. FURTHERMORE, I WILL BE RESPONSIBLE FOR ANY PROFESSIONAL FEES INCURRED FOR DENTAL SERVICE TO MY CHILD. I AUTHORIZE ANY PARTICIPATING DENTAL OFFICE TO RELEASE MY CHILD'S DENTAL RECORDS FOR ADMINISTRATION PURPOSES.

SIGNED _____ **DATE** _____