Gum Disease Specialists
HEALTH HISTORY

It is important that I know about your child's medical history. Many things have a direct bearing on his or her dental health. I will review the questionnaire and discuss it with you in detail. Information you give me is confidential and will not be released to anyone without your written permission.

Patient's Name:_____ Age:_____

Does your child have or had any of the following? Please mark all that apply.

General	**YES**
Anemia	
Diabetes	
Hepatitis	
Allergies	
To penicillin	
To local anesthetic (Novocaine/Lidocaine)	
Abnormal heart condition	
Abnormal bleeding from a cut	
Rheumatic fever	
Heart murmur	
Epilepsy	
Convulsions	

Medications that my child is currently taking:

_____

_____

Dental history

Does dental treatment make your child nervous?

No

Slightly **Moderate** **Severe**

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has any changes in his/her health or change in medication I will inform Dr. Anderson at the next appointment.

X_____

Signature of Parent/Guardian

Date_____

Authorization

Dr. Sig.:_____ Date:_____

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

Payment is due in full at time of treatment unless prior arrangements have been approved.