

MEDICAL HISTORY INFORMATION
 PEDIATRIC DENTAL ASSOCIATES
 SPECIALISTS IN CHILDREN'S DENTISTRY
 6015- 100TH STREET SW LAKEWOOD, WASHINGTON 98499-2733

Patient's Name _____ Patient's Nickname _____

Age _____ Sex _____ Date of Birth _____

Child's physician: Dr. _____ Date of last medical exam: _____

1. Is your child:

In good health? Yes No Taking medication(s)? Yes No
 Under active medical care? Yes No Medicine(s): _____
 Explain: _____ Dose(s): _____

2. Has your child had any history of illness or difficulty with the following? (circle all that apply and explain below)

ADHD	ANEMIA	ASTHMA	AUTISM	BLEEDING DISORDER	CANCER
CEREBRAL PALSY	CLEFT LIP	CLEFT PALATE	DEVELOPMENTAL DELAY	DIABETES	DRUG REACTION
ENDOCRINE SYSTEM	HEART DEFECT, DISEASE, OR MURMUR	HEARING IMPAIRMENT	HEADACHES	HEPATITIS	HIV+ OR AIDS
HYDROCEPHALUS	KIDNEY	LEARNING DISABILITY	LIVER	LUNG DISEASE	SEIZURES
SPEECH DISORDER	THYROID	TUBERCULOSIS	TUMOR	VISION IMPAIRMENT	NONE

3. Parent Comment: (Please explain each item circled above.)

4. Allergies? Yes No If yes, describe: (i.e. drug, food, latex, etc.) _____

5. Has your child been hospitalized or required surgery? Yes No If Yes, describe below:

Date(s): _____

Condition(s): _____

6. Which best describes your child's personality? (circle one)

FRIENDLY SHY NERVOUS STRONG WILLED

7. Additional information: In the space below, please indicate any special concern or provide additional medical information that you think may be useful in providing dental care for your child.

Signature of Parent or Legal Guardian: _____ Printed Name _____

In case of emergency contact: _____

Relationship to patient: _____ Phone: _____

I agree to diagnostic procedures and dental treatments as found necessary and recommended by Daniel H. Cook D.D.S., M.S. and his associates for the above named patient. I authorize the release of any information relative to any insurance claim and authorize payment of my group insurance benefits, otherwise payable to me, to Daniel H. Cook D.D.S., M.S., P.S.

I understand that I am financially responsible to the dentist for any charges not payable by the dental insurance program.

I have informed the office of Daniel H. Cook, D.D.S., M.S. of all applicable dental insurance that covers my child.

Date _____ Signature of Parent or Legal Guardian _____ Printed Name _____

_____ Dental Assistant reviewing history