Koza Family Dental Care, P.C.

Child Medical History

Name & Phone of Child's Physician _____

Does you child have any allergies to medications? _____
If yes, please list _____

Any reactions to local anesthetic? ☐ yes ☐ no

Check all that apply to your child

☐ **Asthma**	☐ **Hearing Loss**
☐ **Heart Disease/ Murmur**	☐ **Epilepsy or Seizures**
☐ **Arthritis**	☐ **Emotional Problems**
☐ **Prolonged Bleeding**	☐ **Physical or Mental Disability**
☐ **Hepatitis**	☐ **Kidney Disease**
☐ **Lung Disease**	☐ **Hay Fever**
☐ **Birth Defect**	☐ **Anemia**
☐ **Diabetes**	☐ **AIDS / AIDS Related Complex**

Does your child require antibiotics prior to dental treatment? ☐ yes ☐ no

Please list all medication your child is taking? _____
_____

Any other medical condition we need to be aware of? ☐ yes ☐ no
If yes, please explain _____

Emergency Contact _____
Relationship _____ Phone Number _____

Childs Dental History

What is the reason for your child's visit today? _____
Is this your child's first dental visit? _____
If not, was the previous visit a good experience? _____
Has your child received local anesthetic before? _____
Did or does your child have a bottle at bed time? _____
Does your child have a thumb or pacifier habit? _____
Who brushes your child's teeth? _____
How often does your child brush? _____ Floss? _____

_____
Signature parent or guardian **Date**