Hamilton Dental Associates Child's Health History

Child's Name: _____Nickname:_____Date of Birth:_____
Age: _____ Sex: M F Height: _____ Weight: _____ Parent's marital status: M S SEP D W
Race: _____ Ethnicity: _____ Language Preference:_____
Name of dental insurance, if any: _____ID#_____
Other children in family (name and ages): _____
Child's Physician:_____Former Dentist:_____
Whom may we thank for referring you to our office? _____

1.Has your child any history of [ ] Heart Trouble, [ ] Emotional, Nervous or Learning Disorder, [ ] Allergies, [ ]Diabetes, [ ] Brain Injury, Kidney or Liver Involvement, [ ] Seizure or Convulsions, [ ] Bleeding Disorder, [ ] Other? _____	**Yes**	**No**
2. Has your child ever been in the hospital overnight, or had any operation? If yes, for what? _____	**Yes**	**No**
3. Is there anything concerning your child's medical history which you feel may be important? _____	**Yes**	**No**
4. Does your child have any allergies? _____	**Yes**	**No**
5. Has your child experienced any unfavorable reaction from previous dental or medical care? _____	**Yes**	**No**
6. Does your drinking water have fluoride? _____	**Yes**	**No**
7. Does your child have any mouth habits, such as [ ] Finger or Thumb Sucking, [ ] Lip Biting, [ ] Other? _____	**Yes**	**No**
8. Is your child under medical care at the present? _____	**Yes**	**No**
9. Is your child taking medication? _____	**Yes**	**No**
10. Does your child smoke? If so how many a day? _____	**Yes**	**No**
11. Is there anything you feel we should know about your child? _____	**Yes**	**No**

I hereby authorize and direct the dentists of Hamilton Dental Associates, assisted by other dentists and/or dental auxiliaries of their choice, to perform upon my child (or legal ward for whom I am empowered to consent) dental services that in their judgment are advisable with exception of _____

Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following the administration of topical fluoride and children biting and injuring their tongue or lip following the administration of local anesthesia. Less common complications include the risks of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown or extracted tooth, injury to the tongue, lips or cheek, damage to and the possible loss existing teeth and or fillings, injury to nerves near the treatment site and fracture to a tooth which may need additional treatment or surgery.
I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that there can be no guarantee as expressed or implied either as to the result of the treatment or as to cure. I understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it. If there is ever a change in my child's health, I will inform the doctor at the next appointment.

Signature, Relationship and Date: _____

Account#_____