CALDWELL COUNTY HEALTH DEPARTMENT

Dental Clinic Medical History and Consent for Routine Examinations and Cleanings

Patient's Name_____

Address_____

City_____ State_____ ZIP_____

Date of Birth_____ Sex___ Phone_____

School_____ Grade_____

City/County water? YES___ NO___

Please check one:

I am the patient's - Parent____ Legal Guardian____

*Please note if you are not the patient's parent, then we need guardianship/custody papers showing you have permission to consent to dental treatment.

*A parent or legal guardian will need to complete a new medical history form every year.

Date of last dental examination:_____

Name of last dentist:_____

To the best of my knowledge, all answers are true and correct. I will inform the dentist at future appointments if there is a change.

I hereby consent for a dental examination to be completed on the patient listed above at the Caldwell County Health Department Dental Clinic every 6 months. This evaluation will include an exam of the child's teeth and mouth and a discussion concerning any treatment needs. This appointment may include x-rays, cleaning, and fluoride treatment depending on the child's age and needs.

YES_____ NO_____

X_____

Parent/Guardian

DATE_____

X_____

Dentist

DATE_____

1. Does your child have any of the following currently or in the past?

	YES	NO
a. Rheumatic Heart Disease	____	____
b. Heart Condition	____	____
c. Food Allergy	____	____
d. Asthma	____	____
e. Diabetes	____	____
f. Kidney Trouble	____	____
g. Liver Trouble	____	____
h. Tuberculosis (TB)	____	____
i. Epilepsy	____	____
j. Sickle Cell Disease	____	____
k. Thyroid Disease	____	____
l. AIDS/HIV	____	____
m. Cleft lip/palate	____	____
n. Cerebral Palsy	____	____
o. Mental handicap	____	____
p. Hearing disability	____	____
q. Hepatitis (A, B, C)	____	____
r. Bleeding disorder	____	____
s. Anemia	____	____
t. Autism	____	____
u. ADHD/ADD	____	____
v. Any other illness or medical condition?	____	____
2. Is your child taking medication now?	____	____
3. Is your child pregnant?	____	____
4. Does your child use tobacco?	____	____
5. Does your child use recreational or illegal drugs?	____	____
6. Has your child ever had a sexually transmitted disease?	____	____
7. Has your child ever had surgery?	____	____
8. Any serious trouble with previous dental treatment?	____	____
9. Any allergic reactions to any of the following:		
a. Local anesthetics (numbing medicine)	____	____
b. Penicillin or other antibiotics	____	____
c. Sulfa drugs	____	____
d. Latex	____	____
e. Other medications or foods	____	____

If "yes" was checked for any of the above questions please explain here. Please also list any medications the patient is taking.

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