

Snoqualmie Valley Kids Dentist
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Snoqualmie, WA 98065
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SnoqualmieValleyKidsDentist.com



Health History

Please answer all questions

	Yes	No		Yes	No
Child's Physician _____			Has your child received a blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Physician's Phone # _____			Are there any emotional problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Is child under care of physician now	<input type="checkbox"/>	<input type="checkbox"/>	Has child ever been hospitalized.....	<input type="checkbox"/>	<input type="checkbox"/>
Is child receiving any medications or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Are there other allergies: food, pollen, etc.....	<input type="checkbox"/>	<input type="checkbox"/>
Is child allergic to any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	If so, what: _____		
If so, what: _____					

HAS CHILD HAD HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING:

Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Bladder problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Measles.....	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV Positive.....	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy-Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects.....	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disabilities.....	<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Physical Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>			

Are there any other conditions other than those listed above that we need to be aware of?

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status; I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist 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 payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Child's Name (print) _____ Signature _____ Date _____

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