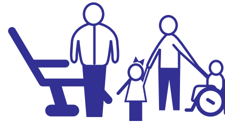
*Diplomate American Board of Pediatric Dentistry

Pediatric Dentistry
John W. Bishop, D.D.S.*
Carlos A. Bertot, D.M.D.*
Kelly C. Mansour, D.M.D.*



Pediatric Dentistry of Central Florida
BISHOP • BERTOT

Orthodontics
John R. Smith, D.D.S., M.S.D.

HEALTH HISTORY UPDATE

Today's Date: (mm/dd/yyyy) _____ /_____ /__________

Child's Name: ______________________________ D.O.B.: ______________________________

Address (list changes only): ____

____

List any dental insurance or financial policy changes: ____

____

New Phone Numbers: Home ____________________ Work ____________________ Cell ____________________

E-mail Address: ____

Child lives with: ❑ Both parents ❑ Mother ❑ Father ❑ Other (list) ______________________________

If not living with both parents, who is legal guardian?: ______________________________

1) Does your child have a heart problem or heart murmur that requires antibiotics before dental treatment?
❑ No ❑ Yes ____

2) Is your child allergic to penicillin or other medicines?
❑ No ❑ Yes (please list) ____

3) Is your child allergic to Latex? ❑ No ❑ Yes

4) Is your child taking any medication?
❑ No ❑ Yes (please list) ____

5) Is your child presently under the care of a physician for any medical problems?
❑ No ❑ Yes (please list) ____

6) Name, Address and phone of child's physician: ____
NAME PHONE

____
STREET CITY STATE ZIP CODE

7) Date of child's last physical exam: ____

8) Has your child had any injuries to the mouth, teeth, or jaw since the last visit?
❑ No ❑ Yes (please list) ____

Consent: I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit references. Furthermore, since your child is a minor, it becomes necessary that a signed permission is obtained from a parent or legal guardian before any and/or all dental services can be started and accomplished by Dr. Bishop, Dr. Bertot, Dr. Mansour and/or legally qualified associates or partners. Such authorization is hereby granted to administer any treatment, anesthetics, and perform such operations or otherwise manage my child as may be deemed necessary or advisable. I understand I will be consulted before any treatment is rendered. I do, however, give specific consent to do an examination, take appropriate x-rays, clean the teeth, give a fluoride treatment, and provide oral hygiene instructions if deemed necessary. I also authorize the use of photographs, radiographs, other diagnostic materials, and treatment records for the purpose of teaching , research, and scientific publications. I also give permission to provide emergency care, if needed. I further understand this consent will remain in effect until such time that I choose to terminate it. If you have any objections to the above, please so state.

Parent or Guardian Print Name: ____

Relationship to Child: ____

Signature: ______________________________ Date: (mm/dd/yyyy) _____ /_____ / __________