*Diplomate American Board of Pediatric Dentistry

**Pediatric Dentistry**
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BERTOT • MANSOUR

**Orthodontics**
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# HEALTH HISTORY AND CONSENT

Date: _____

Child's Name: _____

Address: _____ (STREET / CITY / STATE / ZIP CODE) Phone: _____

Name and address of child's previous dentist: _____ (NAME)

_____ (STREET / CITY / STATE / ZIP CODE)

Name, Address and phone of child's physician: _____ (NAME / PHONE)

_____ (STREET / CITY / STATE / ZIP CODE)

Date of child's last physical exam: _____

How would you describe your child's health? _____

Who is parent's dentist? _____

Does your child have or has he/she had any of the following? Please check a response for each question.

| | Yes | No |
|---|---|---|
| 1. Heart Problems (murmur or surgery) | ❑ | ❑ |
| 1a. Does your child require antibiotics prior to dental treatment? | ❑ | ❑ |
| 2. Rheumatic fever or scarlet fever | ❑ | ❑ |
| 3. Kidney problems | ❑ | ❑ |
| 4. Liver problems or hepatitis | ❑ | ❑ |
| 5. Seizures or epilepsy | ❑ | ❑ |
| 6. Diabetes | ❑ | ❑ |
| 7. Asthma, T.B. or lung problems | ❑ | ❑ |
| 8. Hemophilia or bleeding problems | ❑ | ❑ |
| 9. Syndromes or other genetic disorders | ❑ | ❑ |
| 9a. If Yes explain: _____ | | |
| 10. High or low blood pressure | ❑ | ❑ |
| 11. Surgery or other hospitalization | ❑ | ❑ |
| 12. Emergency hospital care | ❑ | ❑ |
| 13. Cerebral palsy or brain damage | ❑ | ❑ |
| 14. Allergies to any medicines or drugs | ❑ | ❑ |
| 15. If so, what? _____ | | |

| | Yes | No |
|---|---|---|
| 16. Allergic to Penicillin | ❑ | ❑ |
| 17. Sickle cell anemia / blood disorder | ❑ | ❑ |
| 18. Allergies to foods, pollen, etc. | ❑ | ❑ |
| 19. Cancer, tumors or leukemia | ❑ | ❑ |
| 20. Speech or hearing problems | ❑ | ❑ |
| 21. Emotional or mental problems | ❑ | ❑ |
| 22. Learning or school related problems | ❑ | ❑ |
| 23. Cleft lip or palate | ❑ | ❑ |
| 24. Frequent headaches | ❑ | ❑ |
| 25. Malignant hyperthermia | ❑ | ❑ |
| 26. H.I.V. or AIDS | ❑ | ❑ |
| 27. Latex or rubber allergy | ❑ | ❑ |
| 28. Is the parent or patient pregnant? | ❑ | ❑ |
| 29. Vision problems | ❑ | ❑ |
| 30. Thyroid or other glandular problems | ❑ | ❑ |
| 31. Temporomandibular joint problems | ❑ | ❑ |
| 32. Other _____ | | |

| | Yes | No |
|---|---|---|
| 1. Is your child current on his/her immunizations? | ❑ | ❑ |
| 2. Is your child taking **ANY** medicines now (including oral contraceptives) | ❑ | ❑ |
| 2a. If Yes, what medications are they taking_____ | ❑ | ❑ |
| 3. Has the child or any member of the family had any problems with general anesthetics? | ❑ | ❑ |
| 4. Does your child suck his/her thumb or finger, or a pacifier? | ❑ | ❑ |
| 5. Does your child have any form of fluoride? (e.g. city water, vitamin, rinses, toothpaste) | ❑ | ❑ |
| 6. Date and place of last dental visit. _____ | | |
| 7. What was the purpose of that visit? _____ | | |
| 8. Did your child have difficulty cooperating? | ❑ | ❑ |
| 9. Was there any treatment recommended that was not completed? | ❑ | ❑ |
| 10. Has he/she has an unfavorable dental experience? Explain:_____ | ❑ | ❑ |
| _____ | | |
| 11. Is the child's mother or father afraid of dental care? | ❑ | ❑ |
| 12. Is there disagreement between parents regarding dental care? | ❑ | ❑ |
| 13. Does the child's mother or father have crooked teeth? | ❑ | ❑ |
| 14. Is your child adopted? | ❑ | ❑ |
| 15. Has your child had any injuries to the teeth or mouth? | ❑ | ❑ |
| 16. Was/is your child bottle fed? | ❑ | ❑ |
| 17. Was/is your child breast fed? | ❑ | ❑ |
| 18. If your child has been weaned, please indicate at what age. _____ | ❑ | ❑ |
| 19. Has your child had a toothache recently? Explain: _____ | ❑ | ❑ |
| _____ | | |
| 20. Do you expect your child to be cooperative? | ❑ | ❑ |

Purpose of today's visit (any specific concerns)_____

_____

Summary *(to be completed by the doctor)*_____

_____

_____

Consent:

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for 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 service can be started and accomplished by Dr. Carlos Bertot, Dr. Kelly 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 as I choose to terminate it.

If you have any objections to the above, please so state.

Print Name _____ Date: _____
PARENT OR LEGAL GUARDUIAN RELATIONSHIP TO CHILD

Signed_____ Date: _____
PARENT OR LEGAL GUARDUIAN

_____ Date: _____
WITNESS

_____ Date _____
DENTIST