Health History/Cancel Policy Update

Name: _____ Date of Birth: _____

Home Address: _____

City: _____ Zip Code: _____

Parent E-Mail:_____

Phones: Mom Cell: _____ Dad Cell: _____

Is there new dental insurance? Y or N if yes, please provide it to staff at front desk.

Has the child ever had any of the following conditions?

Y	N Current w/ Immunizations?	Y	N Handicaps/Disabilities	Y	N Pregnancy
Y	N Allergies to any Drugs	Y	N Hearing Impairment	Y	N Cancer
Y	N Tuberculosis	Y	N Sight impairment	Y	N Acid Reflux
Y	N Diabetes/Endocrine	Y	N Heart Disease/Murmur	Y	N Pre-Medication
Y	N Any Operations/Surgery	Y	N Hemophilia/Blood disorder		
Y	N Asthma	Y	N Hepatitis		
Y	N Reactive Air Way	Y	N HIV+/AIDS		
Y	N Congenital Birth Defects	Y	N Kidney/Liver Conditions		
Y	N Convulsions/Epilepsy	Y	N Rheumatic/Scarlet Fever		
Y	N Food Allergies	Y	N Allergies to Latex Products		
Y	N Seizures/Fainting	Y	N Sickle Cell Trait/Disease		
Y	N Developmental Delays	Y	N Abnormal Bleeding		

Please list any all drugs the child is currently taking including over the counter medications_____

Please list all drugs the child is allergic to_____

Cancellation Policy

A $50 fee will be assessed on missed appointments with less than 24-hour notice, after 3 missed appointments without 24hrs notice we will no longer be able to schedule an appointment for you. Our time is very important as well as our committed patients.

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this office of any changes in my child's medical status.

_____

Signature of Parent or Guardian Date