Korwin D. King, D.D.S.

CHILD'S MEDICAL HISTORY

DENTAL HISTORY

1. Is this your child's first visit to a dentist? YES NO
2. If not, how long has it been since the last visit? YES NO
3. Were any x-rays taken at any previous visits? YES NO
4. Does your child eat sweets such as candy, gum, pop? YES NO
5. Does your child receive fluoride in any form? YES NO
6. Have any cavities been noted in the past? YES NO
7. Were any baby teeth removed by extraction? YES NO
8. Have there been any injuries to teeth? YES NO
9. Has your child ever received local anesthetic? YES NO

MEDICAL HISTORY

1. Name of child's physician ____
2, Please indicate any health problems ________________________________

____

3. Please indicate any medications your child is currently taking __________

____

4. Please indicate any allergies to drugs such as penicillin, other antibiotics, etc. ____
5. Is your child allergic to latex or any metals? YES NO
6. Has your child ever had surgery? YES NO
7. Is your child subject to severe or prolonged bleeding? YES NO
8. Please circle any appropriate responses: Has your child had any history of diabetes, heart trouble, asthma, AIDS, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, cancer problems, eyesight problems, speech impairments, mental retardation, hearing loss, fainting, dizziness, frequent headaches.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT/GUARDIAN SIGNATURE ______________________________

DATE ___________________