



HEALTH HISTORY UPDATE

Child's Full Name(w/ middle initial) _____

Birthdate: _____ **Phone #s(Mobile:)** _____ **(Home:)** _____

Email address: _____

Address _____

Has the child experienced any of the following in the last 3 years?

- | | | |
|-------------------------------------|------------------------------------|------------------------------------|
| Y N Abnormal bleeding | Y N Allergies to any Drugs | Y N Any Hospital Stays |
| Y N Any Operations | Y N Asthma | Y N Cancer |
| Y N Congenital Heart Disease | Y N Convulsions/Epilepsy | Y N Allergies to Latex |
| Y N Handicaps/Disabilities | Y N Hearing Impairment | Y N Heart Murmur |
| Y N Hemophilia | Y N Hepatitis | Y N HIV+/AIDS |
| Y N Kidney/Liver Problem | Y N Rheumatic/Scarlet Fever | Y N Frequent ear infections |
| Y N ADD/ADHD | Y N Autism | Y N Cerebral Palsy |

Please explain any serious medical problems the child has had _____

Please list all the drugs the child is taking _____

Please list all drugs and/or foods the child is allergic to _____

Does your child require a pre medication prior to a dental appointment for any medical condition? YES NO

If yes, Why? _____

I give Just Kidz Dentistry permission to communicate with me via the following options:

___ Phone ___ Texts ___ Postal Mail ___ Email

I herby give consent for Just Kidz Dentistry permission to use pictures of my child for social media & education. YES NO

Does he/she currently participate in sports? YES NO

Have you received a copy of your privacy rights? YES NO

PARENT/GUARDIAN INITIALS _____ **DATE:** _____