



### 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 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 hereby 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: \_\_\_\_\_

EP 07/2025