SPD 2019(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Is your child under a physician's care now?	◯ Yes ◯ No	If yes
Has your child ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Has your child ever had a serious head or neck injury?	◯ Yes ◯ No	If yes

Does your child have, or has your child had, any of the following?

Anaphylaxis	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Hives or Rash	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Cancer Diagnosis	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Autism/Asperger's	◯ Yes ◯ No	Hearing Loss	◯ Yes ◯ No	Developmental Delays	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Reflux/GI Issues	◯ Yes ◯ No	Learning Disability	◯ Yes ◯ No	ADD or ADHD	◯ Yes ◯ No
Vision Loss/Eyewear	◯ Yes ◯ No						

Has your child ever had a serious illness, surgery, or condition not listed above?	◯ Yes ◯ No	If yes

Please list ANY food or medication allergies below

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____