Gateway Dental
Wells Fargo Center
999 Third Ave, Plaza 18
Seattle, WA 98104

CHART NUMBER

Child's Medical History

Child's name: **Date:**

Parent/Guardian: **Phone:**

Child's physician: **Physician's phone:**

Why have you brought your child to visit us today?

Is this your child's first time seeing a dentist? ☐ **YES** ☐ **NO** **Date of last visit:**

Has your child ever had problems with any previous dental treatment? If "YES", please explain:

Has your child ever been hospitalized? ☐ **YES** ☐ **NO**

Please list dates and reasons:

Is your child allergic to any of the following:

Local injected anesthetics (Novocain)	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Other:	☐ Yes	☐ No
If other, specify:		

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Has your child ever been treated for any of the following:

Arthritis	☐ Yes	☐ No		Heart Murmur	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No		Hepatitis	☐ Yes	☐ No	
Bleeding Disorder	☐ Yes	☐ No		Joint Replacement or Prosthetic	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No		Lung Disease or Tuberculosis	☐ Yes	☐ No	
Emotional Problems	☐ Yes	☐ No		Prolonged Bleeding	☐ Yes	☐ No	
Fainting Spells	☐ Yes	☐ No		Rheumatic Fever	☐ Yes	☐ No	
Hearing Loss	☐ Yes	☐ No		Seizures	☐ Yes	☐ No	
Heart Disease	☐ Yes	☐ No					

Has your child ever had any serious illness that is not yet mentioned? If so, please explain:

Current medications your child is taking:

What else would you like us to know about your child?

Signed: _____ Date signed: _____

Parent/Guardian signature

Signed: _____ Date signed: _____

Doctor signature