MEDICAL HISTORY Child's Name _____ Weight _____

CURRENT ADDRESS/PHONE _____

Place a mark on yes or no for each of the following.

ADD/ADHD	☐ Yes ☐ No	Drug/Alcohol Abuse	☐ Yes ☐ No	Reflux	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Sensory Process Disorder	☐ Yes ☐ No
Asperger's	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sickle Cell	☐ Yes ☐ No
Autism	☐ Yes ☐ No	Heart Valve Replacement	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Bladder Issues	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Skin Disorder	☐ Yes ☐ No
Bleeding Issues	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Speech Problem	☐ Yes ☐ No
Cancer/Tumors	☐ Yes ☐ No	Kidney/Stomach Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cerebral Palsy	☐ Yes ☐ No	Learning Disabilities	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cleft Palate	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Other:	
Hearing Loss	☐ Yes ☐ No	Measles	☐ Yes ☐ No	_____	
Chicken Pox	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Are you on well water?	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Radiation/Chemotherapy	☐ Yes ☐ No	**Girls:** Are you pregnant?	☐ Yes ☐ No

If you said yes for the following, please provide additional information:

Asthma When was your child's last attack? _____ Ever hospitalized? When? _____

Epilepsy When was your child's last seizure? _____ Ever hospitalized? When? _____

Child's Pediatrician _____ City/State _____

Pediatrician Phone # _____ Date of last exam: _____

Any health concerns? _____

MEDICATIONS List any medications that your child is currently taking and the correlating diagnosis: _____

_____

ALLERGIES ☐ NONE ☐ Penicillin/Amoxicillin ☐ Latex ☐ Aspirin ☐ Sulfa ☐ Metal ☐ Local Anesthetic

☐ Other - List _____

SIGNATURE: _____ (signature) _____ (date)

SIGNATURE: _____ (signature) _____ (date) _____ (UPDATED weight)

SIGNATURE: _____ (signature) _____ (date) _____ (UPDATED weight)

SIGNATURE: _____ (signature) _____ (date) _____ (UPDATED weight)

SIGNATURE: _____ (signature) _____ (date) _____ (UPDATED weight)

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

> While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
>
> Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY _____ DATE _____

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	_____ YES	_____ NO
DO YOU HAVE A FEVER?	_____ YES	_____ NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	_____ YES	_____ NO
DO YOU HAVE A DRY COUGH?	_____ YES	_____ NO
DO YOU HAVE A RUNNY NOSE?	_____ YES	_____ NO
DO YOU HAVE A SORE THROAT?	_____ YES	_____ NO
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	_____ YES	_____ NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	_____ YES	_____ NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES?	_____ YES	_____ NO

IF SO, WHERE? _____

After filling out this form, please save, and email to frontdesk@growbigsmiles.com