Glaser Dental
24 Brown Boulevard
Rothschild, WI 54474
Phone: 715.359.4344
Fax: 715.359.7733
Email: smile@tylerglaserdental.com

Please answer all questions

Health History – Child

Glaser Dental requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs.

No persons outside Glaser Dental will be provided this information unless properly authorized by you or required by law. Failure to provide the requested information will limit our ability to assess your needs and may result in Glaser Dental being unable to accept you as a patient. Thank you.

_____
Child's Name (print)

	Yes	No
Child's Physician _____		
Physician's Phone # _____		
Is child under care of physician now	❑	❑
Is child receiving any medications or drugs?	❑	❑
Is child allergic to any drugs?	❑	❑
If so, what:		

_____

	Yes	No
Has your child received a blood transfusion	❑	❑
Are there any emotional problems	❑	❑
Has child ever been hospitalized	❑	❑
Are there other allergies: food, pollen, etc.	❑	❑
If so, what:		

_____

HAS CHILD HAD HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING:

Heart Trouble	❑	❑	Cancer	❑	❑
Heart Murmur	❑	❑	Kidney Disease	❑	❑
Anemia	❑	❑	Bladder problems	❑	❑
Rheumatic Fever	❑	❑	Liver Disease	❑	❑
Hepatitis	❑	❑	Measles	❑	❑
Jaundice	❑	❑	Cerebral Palsy	❑	❑
AIDS/HIV Positive	❑	❑	Mononucleosis	❑	❑
Bronchitis	❑	❑	Hearing Trouble	❑	❑
Asthma	❑	❑	Mumps	❑	❑
Tuberculosis	❑	❑	Chicken Pox	❑	❑
Diabetes	❑	❑	Abnormal Bleeding	❑	❑
Epilepsy-Seizures	❑	❑	Sinus Trouble	❑	❑
Joint Replacement	❑	❑	Birth Defects	❑	❑
Learning Disabilities	❑	❑	Attention Deficit Disorder	❑	❑
Physical Treatment	❑	❑			

Please list all medications the child is currently taking.

_____

_____

Are there any other conditions other than those listed above that we need to be aware of?

_____

_____

AUTHORIZATION

I have reviewed the information on this questionaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status; I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I understand the use of anesthetic agents embodies a certain risk. The risks include, but are not limited to pain, swelling, bruising and permanent anesthesia.

I authorize the dentist to release all information necessary to secure payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.

_____ _____ _____

Parent or Guardian Name (print) Signature Date