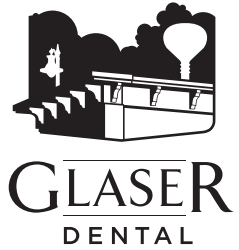


Glaser Dental
 24 Brown Boulevard
 Rothschild, WI 54474
 Phone: 715.359.4344
 Fax: 715.359.7733
 Email: smile@tylerglaserdental.com



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..... Yes No

Is child receiving any medications or drugs?..... Yes No

Is child allergic to any drugs?..... Yes No

If so, what: _____

Yes No

Has your child received a blood transfusion Yes No

Are there any emotional problems Yes No

Has child ever been hospitalized..... Yes No

Are there other allergies: food, pollen, etc. Yes No

If so, what: _____

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

Heart Trouble.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder problems.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jaundice.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cerebral Palsy.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS/HIV Positive.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Trouble.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal Bleeding.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy-Seizures.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Replacement.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Defects.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Learning Disabilities.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Attention Deficit Disorder.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Treatment.....	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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 questionnaire, 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