Bellevue Kids Dentist
2150 112th Ave. NE #A
Bellevue, WA 98004
Ph: 425-455-0784
Fax: 425-451-3999

Health History

Please answer all questions

	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	❑	❑
Heart Murmur	❑	❑
Anemia	❑	❑
Rheumatic Fever	❑	❑
Hepatitis	❑	❑
Jaundice	❑	❑
AIDS/HIV Positive	❑	❑
Bronchitis	❑	❑
Asthma	❑	❑
Tuberculosis	❑	❑
Diabetes	❑	❑
Epilepsy-Seizures	❑	❑
Joint Replacement	❑	❑
Learning Disabilities	❑	❑
Physical Treatment	❑	❑

Cancer	❑	❑
Kidney Disease	❑	❑
Bladder problems	❑	❑
Liver Disease	❑	❑
Measles	❑	❑
Cerebral Palsy	❑	❑
Mononucleosis	❑	❑
Hearing Trouble	❑	❑
Mumps	❑	❑
Chicken Pox	❑	❑
Abnormal Bleeding	❑	❑
Sinus Trouble	❑	❑
Birth Defects	❑	❑
Attention Deficit Disorder	❑	❑

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

Child's Name (print) _____ Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been made.