JULIE A. VEERMAN, DDS, LLC

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: _____Date of Birth: _____

CHILD MEDICAL HISTORY

Name of child's physician_____Phone Number_____
Does your child have any allergies to medications? ☐ Y or N ☐
If yes, please list_____
Any reactions to local anesthetic? Y or N
Circle all that apply to your child: ☐ ☐

- ☐ Asthma
- ☐ Heart Disease/Murmur
- ☐ Diabetes
- ☐ Arthritis
- ☐ Prolonged Bleeding
- ☐ Hepatitis
- ☐ Lung Disease
- ☐ Birth Defects
- ☐ Hearing loss
- ☐ Epilepsy or Seizures
- ☐ Emotional Problems
- ☐ Physical or Mental Disability
- ☐ Kidney Disease
- ☐ Hay Fever
- ☐ Anemia
- ☐ AIDS/AIDS related complex

Any other medical conditions?_____
Has your child had the HPV(Gardasil-9) vaccination ☐ Y or N ☐
Does your child require an antibiotic prior to dental treatment? ☐ Y or N ☐
List medications your child is taking_____
Emergency contact_____ Relationship_____Phone_____

CHILD DENTAL HISTORY

What is the reason for your child's visit today? ☐ Routine care or Emergency treatment ☐
Is this your child's first dental visit? ☐ Y or N ☐
If not, was the previous visit a good one? ☐ Y or N ☐
Has your child received local anesthetic before? ☐ Y or N ☐
Did or does your child have a bottle at nap or bed time? ☐ Y or N ☐
Does your child have a thumb habit or pacifier? ☐ Y or N ☐

Who brushes your child's teeth?_____
How often are your child's teeth brushed?_____
How often are your child's teeth flossed?_____

Has your child had a serious problem at a previous dental visit? ☐ Y or N ☐
If yes, please explain_____
Do you believe your child can tolerate routine dental care? ☐ Y or N ☐
If not, please explain_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating my child. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Parent/Legal Guardian Date