

Snoqualmie Valley Kids Dentist  
 34929 SE Ridge St. #220  
 Snoqualmie, WA 98065  
 Ph: 425-396-1011  
 Fax: 425-396-1258



## Health History

*Please answer all questions*

	Yes	No		Yes	No
Child's Physician _____			Has your child received a blood transfusion .....	<input type="checkbox"/>	<input type="checkbox"/>
Physician's Phone # _____			Are there any emotional problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Is child under care of physician now .....	<input type="checkbox"/>	<input type="checkbox"/>	Has child ever been hospitalized.....	<input type="checkbox"/>	<input type="checkbox"/>
Is child receiving any medications or drugs? .....	<input type="checkbox"/>	<input type="checkbox"/>	Are there other allergies: food, pollen, etc.....	<input type="checkbox"/>	<input type="checkbox"/>
Is child allergic to any drugs? .....	<input type="checkbox"/>	<input type="checkbox"/>	If so, what: _____		
If so, what: _____					

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

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

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

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### 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 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.*