KOHLMEIER DENTAL LLC

HEALTH HISTORY (MINOR)

Patient Name: _____

DOB: _____

Summary

Medical Conditions	
Allergies	

Healthcare Provider

Child's Physician/Pediatrician:	
Physician/Pediatrician phone number:	
Address:	
Preferred Pharmacy:	
Date of last physical exam:	

General Health Information

Does your child have any allergies?	
Is your child currently taking any medications?	
Has your child ever been hospitalized, had general anesthesia, or emergency room visits? If yes, provide details.	

Please list all medications, doses and reason:

_____

_____

Medical Conditions

Have you ever been told that your child needs to take antibiotics before dental treatment? If yes, provide details.	
Is your child currently being treated for, or has history of any medical conditions? If yes, provide details.	

Parent's signature: _____ Date: _____