Child's Name: _____

Health History

If your child has, and has had any of the following, please circle Y (Yes) or N (No):

Y N Asthma	Y N Abnormal Bleeding	Y N Allergies to any drug
Y N Hepatitis	Y N HIV/ AIDS	Y N Hemophilia
Y N Heart Disease	Y N Cancer	Y N Diabetes
Y N Congenital Heart Defect	Y N Latex Allergy	Y N Mental Problems
Y N Seizures/ Convulsions	Y N Handicaps/ Disabilities	Y N Tuberculosis
Y N Speech/ Hearing Problems	Y N Kidney/ Liver Problems	Y N Rheumatic Fever

Please explained any above problems that were checked or any problems not listed: _____

_____

Please discuss any serious medical problems or hospitalizations that your child has had: _____

_____

Please list all allergies, sensitivities, and/ or reactions: _____

_____

Please list all medications your child currently takes: _____

Please list any history of behavioral or emotional problems your child has experienced: _____

_____

Home Water Supply: ____ City ___ Well ___ Spring ___ Bottled

Does your child have the following habits? ___ Bottle ___Grinds Teeth ___ Chews Hard Objects ___ Pacifier

___ Tongue Thrust ___ Finger/ Thumb Sucking

Has your child had difficulty with previous medical or dental visits? _____

Do you have difficulty at home brushing your child's teeth? _____

Who may we thank for your referral? _____

I hereby assign to Dr. Gentzler all money which I am entitled for dental expense relative to the service rendered by him, but not to exceed my indebtedness to said dentist. It is understood that any money received from the above named insurance company, over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctor for charges not covered by this agreement. I further agree in the event of non-payment, to bear the cost of collection, and/ or court cost, and reasonable legal fees should this be required, and interest of 1 ½% per month (18% APR). Also, I authorize Dr. Gentzler to render any treatment deemed necessary for my child's health, after having discussed treatment with me; including the use of nitrous oxide. Appointments cancelled without a 24 hour notice will be subject to a service charge of $25.00

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I authorize the healthcare staff to perform the necessary services my child may need, after having discussed treatment with the doctor.

Parent/ Guardian's Signature _____ Date _____