



_____			
3.	Name of physician: _____ Phone: _____		
4.	Is your child receiving any medication? What type? _____	YES	NO
5.	Is your child allergic to penicillin, antibiotics, or other drugs?	YES	NO
6.	Is your child allergic to or sensitive to any metals or latex?	YES	NO
7.	Does your child have other allergies?	YES	NO
8.	Has your child had any serious illness? When? _____ What? _____	YES	NO
9.	Has your child ever had surgery?	YES	NO
10.	Does your child have a heart murmur?	YES	NO
11.	Is surgery contemplated?	YES	NO
12.	Does your child experience severe or prolonged bleeding?	YES	NO
13.	Does your child have AIDS or tested HIV positive?	YES	NO
14.	Has your child tested positive for hepatitis or TB?	YES	NO
15.	Is your child subject to nervous disorders? Fainting? Seizures? Dizziness? Behavioral/Learning problems?	YES	NO
16.	Does your child have frequent headaches?	YES	NO
17.	Has your child had history of: (circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss. Any other illness? _____	YES	NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

DENTIST'S SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

ANEST.
MED ALERT

COMMENTS
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