



**Pediatric Dentistry of Central Florida**  
BISHOP • BERTOT

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*Diplomate American Board of Pediatric Dentistry*

**Pediatric Dentistry**  
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**Orthodontics**  
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**HEALTH HISTORY AND CONSENT**

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
STREET CITY ZIP CODE

Name and address of child's previous dentist: \_\_\_\_\_  
NAME

\_\_\_\_\_  
STREET CITY STATE ZIP CODE

Name, Address and phone of child's physician: \_\_\_\_\_  
NAME PHONE

\_\_\_\_\_  
STREET CITY STATE ZIP CODE

Date of child's last physical exam: \_\_\_\_\_

How would you describe your child's health? \_\_\_\_\_

Who is parent's dentist? \_\_\_\_\_

Does your child have or has he/she had any of the following? Please check a response for each question.

- |   | Yes                      | No                       |   | Yes                      | No                       |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Heart Problems (murmur or surgery) . . . . .                                 | <input type="checkbox"/> | <input type="checkbox"/> | 16. Allergic to Penicillin . . . . .              | <input type="checkbox"/> | <input type="checkbox"/> |
| 1a. Does your child require antibiotics<br>prior to dental treatment? . . . . . | <input type="checkbox"/> | <input type="checkbox"/> | 17. Sickle cell anemia / blood disorder . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Rheumatic fever or scarlet fever . . . . .                                   | <input type="checkbox"/> | <input type="checkbox"/> | 18. Allergies to foods, pollen, etc. . . . .      | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Kidney problems. . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | 19. Cancer, tumors or leukemia. . . . .           | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Liver problems or hepatitis. . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | 20. Speech or hearing problems . . . . .          | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Seizures or epilepsy . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | 21. Emotional or mental problems . . . . .        | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Diabetes . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | 22. Learning or school related problems . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Asthma, T.B. or lung problems . . . . .                                      | <input type="checkbox"/> | <input type="checkbox"/> | 23. Cleft lip or palate . . . . .                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Hemophilia or bleeding problems . . . . .                                    | <input type="checkbox"/> | <input type="checkbox"/> | 24. Frequent headaches . . . . .                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Syndromes or other genetic disorders . . . . .                               | <input type="checkbox"/> | <input type="checkbox"/> | 25. Malignant hyperthermia . . . . .              | <input type="checkbox"/> | <input type="checkbox"/> |
| 9a. If Yes explain: _____   |                          |                          | 26. H.I.V. or AIDS . . . . .                      | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 27. Latex or rubber allergy . . . . .             | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. High or low blood pressure . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | 28. Is the parent or patient pregnant? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Surgery or other hospitalization . . . . .                                  | <input type="checkbox"/> | <input type="checkbox"/> | 29. Vision problems . . . . .                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Emergency hospital care . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | 30. Thyroid or other glandular problems . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Cerebral palsy or brain damage . . . . .                                    | <input type="checkbox"/> | <input type="checkbox"/> | 31. Temporomandibular joint problems . . . . .    | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Allergies to any medicines or drugs . . . . .                               | <input type="checkbox"/> | <input type="checkbox"/> | 32. Other _____                                   |                          |                          |
| 15. If so, what? _____  |                          |                          |   |                          |                          |

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Is your child current on his/her immunizations? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is your child taking <b>ANY</b> medicines now (including oral contraceptives) . . . . .             | <input type="checkbox"/> | <input type="checkbox"/> |
| 2a. If Yes, what medications are they taking _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the child or any member of the family had any problems with general anesthetics?. . . . .       | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does your child suck his/her thumb or finger, or a pacifier? . . . . .                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does your child have any form of fluoride? (e.g. city water, vitamin, rinses, toothpaste) . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Date and place of last dental visit. _____  |                          |                          |
| 7. What was the purpose of that visit? _____   |                          |                          |
| 8. Did your child have difficulty cooperating? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Was there any treatment recommended that was not completed? . . . . .                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has he/she has an unfavorable dental experience? Explain: _____                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/>  |                          |                          |
| 11. Is the child's mother or father afraid of dental care? . . . . .                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Is there disagreement between parents regarding dental care? . . . . .                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does the child's mother or father have crooked teeth? . . . . .                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Is your child adopted? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Has your child had any injuries to the teeth or mouth? . . . . .                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Was/is your child bottle fed? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Was/is your child breast fed? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. If your child has been weaned, please indicate at what age. _____                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Has your child had a toothache recently? Explain: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/>  |                          |                          |
| 20. Do you expect your child to be cooperative?. . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |

Purpose of today's visit (any specific concerns) \_\_\_\_\_

Summary (to be completed by the doctor) \_\_\_\_\_

**Consent:**

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for treatment of my child or for the purpose of payment of the account or credit references.

Furthermore, since your child is a minor, it becomes necessary that a signed permission is obtained from a parent or legal guardian before any and/or all dental service can be started and accomplished by Dr. John Bishop, Dr. Carlos Bertot and/or legally qualified associates or partners.

Such authorization is hereby granted to administer any treatment, anesthetics, and perform such operations or otherwise manage my child as may be deemed necessary or advisable. I understand I will be consulted before any treatment is rendered. I do, however, give specific consent to do an examination, take appropriate x-rays, clean the teeth, give a fluoride treatment, and provide oral hygiene instructions if deemed necessary. I also authorize the use of photographs, radiographs, other diagnostic materials, and treatment records for the purpose of teaching, research, and scientific publications. I also give permission to provide emergency care, if needed.

I further understand this consent will remain in effect until such time as I choose to terminate it.

**If you have any objections to the above, please so state.**

Print Name \_\_\_\_\_ Date: \_\_\_\_\_  
PARENT OR LEGAL GUARDIAN RELATIONSHIP TO CHILD

Signed \_\_\_\_\_ Date: \_\_\_\_\_  
PARENT OR LEGAL GUARDIAN

\_\_\_\_\_ Date: \_\_\_\_\_  
WITNESS

\_\_\_\_\_ Date: \_\_\_\_\_  
DENTIST