



Beth A. Loew, D.D.S.
 2164 Riverside Drive
 Columbus, Ohio 43221
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UPDATED MEDICAL INFORMATION

CHILD INFORMATION

Name: _____ Male Female Birth Date: ____ / ____ / ____
LAST FIRST MI

Home Address: _____
APT / CONDO # CITY STATE ZIP

Referred By: _____

Physician's Name: _____ **Physician's Phone:** () _____

With Whom does the patient live: _____ **Relationship:** _____

Medical / Dental History

Has your child had any of the following medical or dental conditions / problems?
 Please mark the appropriate answers and fill in the blanks.

Medical History

- Yes No Heart murmur
- Yes No Heart problems
- Yes No Rheumatic Fever
- Yes No Bleeding problems
- Yes No Hemophilia
- Yes No Asthma
- Yes No Allergy to any drugs
- Yes No Allergy to latex or plastic
- Yes No Genetic Disorders
- Yes No Disabilities / Handicaps
- Yes No Hearing problems
- Yes No Vision problems
- Yes No Cancer / Radiation / Chemo
- Yes No Diabetes
- Yes No HIV / AIDS
- Yes No Tuberculosis
- Yes No Hepatitis
- Yes No Kidneys / Liver problems
- Yes No Epilepsy / Convulsions
- Yes No Bone / Joint problems
- Yes No Hospitalizations
- Yes No Surgeries
- Yes No Other medical problems or conditions (Specify)

- Yes No Current medications (list)

Dental History

- Yes No Injuries to jaws or teeth
- Yes No Toothaches
- Yes No Abscesses (gum boils)
- Yes No Frequent mouth sores
- Yes No Bleeding gums
- Yes No Thumb / Finger sucking habit
- Yes No Lip / Tongue biting habit
- Yes No Clenching or grinding habit
- Yes No Flouridated water
- Yes No Flouride rinses / Supplements
- Yes No Teeth brushed daily
- Yes No Teeth flossed daily
- Yes No Other dental problems or conditions (Specify)

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

 Signature of parent or guardian

 Date

Office Use Only
Medical History Review & Update

I have reviewed the medical / dental information above with the parent / guardian and patient named herein.

Date	Signature	Date	Signature
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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