



Sandra Armstrong, D.D.S.

PEDIATRIC AND ADOLESCENT DENTISTRY
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HEALTH HISTORY	YES	NO	COMMENTS
MEDICATIONS			
ALLERGIES/DRUG ALLERGIES			
SURGERY/HOSPITALIZATION			
UP-TO-DATE IMMUNIZATIONS			
HEART CONDITION			
LUNG PROBLEMS			
ASTHMA			
ANEMIS/SICKLE CELL ANEMIA			
BEHAVIORAL PROBLEMS			
BLOOD TRANSFUSION/BLEEDING DISORDERS			
CEREBRAL PALSY			
CHICKEN POX			
DIABETES			
EMOTIONAL DISORDER			
EPILEPSY			
HEPATITIS			
HEARING/SPEECH PROBLEMS			
KIDNEY PROBLEMS			
LIVER PROBLEMS			
MENTAL RETARDATION			
MUMPS/MEASLES			
MONONUCLEOSIS			
PREGNANCY			
RHEUMATIC FEVER			
THYROID DISORDERS			
TUBERCULOSIS			
VISION PROBLEMS			
OTHER			

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment.

Because your child is a minor, it is necessary that signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment is performed.

The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto.

This consent shall remain in full force and effect until canceled by either party. Furthermore, the undersigned agrees to be responsible for any bill occurred on this child for dental treatment should named responsible party fail.

Date _____ Signature _____

Patient's Name _____

HEALTH HISTORY FORM

www.catchawinningsmile.com