Matthew H. Wallengren, D.D.S., P.A.
600 Wyndhurst Avenue, Suite 270
Baltimore, MD 21210

CHILD MEDICAL HISTORY

Patient's Name _____ DOB _____

Parent's/ Legal Guardian's Name _____
Parent's cell # _____ Office # _____ Home # _____
Physician's Name _____

Address _____ Office # _____

NOTES:

DENTAL HISTORY

1.	Is this your child's first visit to the dentist?.....	Yes	NO
2.	If not, how long has it been since the last visit to the dentist? _____		
3.	Has your child had any unfavorable dental visits?.....	YES	NO
4.	Have there been any injuries to the teeth or mouth?.....	YES	NO
5.	Has your child ever had occlusal sealants?.....	YES	NO

MEDICAL HISTORY

1.	Is your child in good health?.....	YES	NO
2.	Is your child under the care of a physician?.....	YES	NO
	If yes, since when? _____ Why? _____		
3.	Is your child receiving any medication?	YES	NO
4.	If so, please list _____		
	_____		
	_____		
5.	Has your child had any serious illness? When? _____ What? _____		
6.	Is your child allergic to penicillin, antibiotics, other drugs?.....	YES	NO
7.	If so, please list drug /food dye allergies _____		
	_____		
	_____		
8.	Has your child has surgery?.....	YES	NO
9.	Is your child typically prone to anxiety?.....	YES	NO
10.	Does your child have a history of: diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache, ear infection or any other medical condition?.....	YES	NO
11.	Is there anything else we should know about your child's health that we have not covered in this form?.....	YES	NO
	If so, please list _____		
	_____		
	_____		

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Parent/Guardian Signature: _____ **Date** _____

Doctor's Signature: _____ **Date** _____