HENDERSONVILLE
PEDIATRIC DENTISTRY
ANDREW S. MCKENZIE DDS,PA

Current Medical History

Child's Name: _____ Age: _____

Date of Birth: _____ Email: _____

Phone: _____ Address: _____

Insurance Carrier (Please Provide Card):_____

Does your child/teen have any of the following? Please circle.

| | | |
|---|---|---|
| Allergies | Fainting | Pregnancy/Nursing |
| Anemia | Hearing Disorder | Rheumatic Fever |
| Asthma | Heart Disease | Seizures/Epilepsy |
| Autism | Hepatitis | Special Needs |
| Bleeding Disorder | Kidney or Liver Disease | Speech Disorder |
| Diabetes | Mental Disorder | AIDS/HIV |
| Cold/Virus | Nervous/Sensory Disorder | Developmental Delay |

Other: _____

Is your child taking any medication at this time? _____
If so, please list: _____

Has your child been hospitalized since your last visit to our office? _____
If so, where and why? _____

Has your child had any unfavorable reactions or allergies to any medication such as penicillin or codeine?
_____ List if any: _____

**Today's visit will include fluoride and any necessary x-rays.**

_____
Signature of Parent or Guardian Date

Please **check** relationship to patient: ◯ **Biological Parent** ◯ **Legal Guardian** ◯ **Other: _____**

_____
If patient is 18 years old or older signature Approved ID Issue Date