CHILDREN’S DENTISTRY

Patient Update

Today's Date ______________________________

Patient Name ____

Patient DOB ____

Relation to Patient & Name ____

Phone Number ____

Cell Phone Number ____

ADDRESS ____

CITY, STATE, & ZIP____

Email ____

Would you like to be contacted by email? _____ YES _____ NO

Would you like to be contacted by text message? _____ YES _____ NO

HAVE YOU HAD A CHANGE IN DENTAL INSURANCE? YES OR NO

POLICY HOLDER’S PLACE OF EMPLOYEMENT

____

***IF YES, PLEASE PROVIDE THE FRONT DESK WITH YOUR NEW INSURANCE CARD.**

CHILDREN'S DENTISTRY
MEDICAL HISTORY UPDATE

PATIENT NAME: ____ **DATE OF BIRTH:** ____________________________
PATIENT ADDRESS: ____ **PATIENT PHONE:** ___________________________
____

PATIENT INFORMATION:
Has there been any change in address or phone number? Yes No
If Yes, please write all updated information.)

INSURANCE
Has there been any change in insurance? (If Yes, please give card to receptionist) Yes No

GENERAL HEALTH HISTORY (Please check all that apply. List others below.)

ADD/ADHD YES NO	AIDS/HIV1 YES NO	ASTHMA YES NO	AUTISM YES NO
BLOOD DISORDER YES NO	CANCER YES NO	CEREBRAL PALSY YES NO	DEVELOPMENTALLY DELAYED YES NO
DIABETES YES NO	DOWN'S SYNDROME YES NO	EMOTIONAL PROBLEMS YES NO	EYE PROBLEMS YES NO
EAR PROBLEMS YES NO	HEART CONDITION YES NO	HEPATITIS YES NO	KIDNEY CONDITION YES NO
LIVER CONDITION YES NO	SICKLE CELL YES NO	SEIZURES YES NO	SPECIAL NEEDS YES NO
SPEECH PROBLEMS YES NO	STOMACH PROBLEMS YES NO	TUBERCULOSIS YES NO	FAINTING YES NO
OTHER:			

MEDICAL HISTORY
Has there been any change in child's medical history? Yes No If yes____

Does your child currently take any medications? Yes No if yes ____

Allergies:
Is patient allergic to any food, drugs, or latex: Please list others below.
Penicillin Yes No
Amoxicillin Yes No
Latex Yes No
Sulfa Drugs Yes No

Other: ____

PERSONAL HEALTH HISTORY
Does your child suck thumb, finger or pacifier? Yes No
Is your child currently breast or bottle feeding: Yes No
Does your child use a sippy cup? Yes No
Does your child drink soda? Yes No
Is your child currently seeing an orthodontist? Yes No If yes ____
Do you brush your child's teeth? Yes No
Does your child brush his/her own teeth? Yes No
Does your child use dentla floss? Yes No
Do you have flouride in your water system? Yes No
Are your child's immunizations up to date? Yes No
Is your child currently under the care of a physician? Yes No If yes ____
Has your child had any operations/hospitalizations? Yes No if yes ____

CHILD'S HEALTH AND PERSONAL SAFETY
Caffeine Yes No Coffee Yes No Tea Yes No
Alchohol Yes No Tobacco Yes No Cola Yes No
Drugs Yes No If yes ____

Name of local Friend or Relative:_________________________________Relationship:_____________________Phone:________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in medical status. I am a parent, guardian or personal relative of __________________________________ and there are no court orders now in effect that prohibit me from signing this consent. I request and authorize the dental staff to perform necessary dental services for me/my child, including but not limited to xrays, and administration of anesthesia, which are deemed advisable by the doctor, whether or not I am present when treatment is rendered. I authorize the dentist to release any information including diagnosis and records of treatment or examination rendered to me/my child during the period of such Dental care to third party payors/health practitioners.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: ____

DATE: ____