Today's Date: _______________

MEDICAL UPDATE FORM

Patient's Name: ____
Last First MI

Sex: M F Date of Birth: ___________________ Age: _________

School:_____________________ Grade:___________ Hobbies/Sports: ________________________________

Who is Accompanying Your Child Today?

Name: ____________________________________ Relation:___________________________

Parent's Marital Status (circle one that best applies): Single Widowed Separated Married Divorced
Brothers/ Sisters & Ages:
____

Person Responsible For Account

Name: ____ Relation: ________________________

BILLING ADDRESS:____
Street City State Zip

BEST NUMBER TO CONFIRM APPOINTMENTS: ____________________________________

Guardian #1 Name: ____ ________________
Last First Occupation

DOB: ____________________ Employer: _________________________ Home #: _____________________
Cell #: ____________________ Work #: __________________________ E-mail: ______________________
SS#______________________ DRIVERS LICENSE# __________________________________

Guardian #2 Name: ____ ________________
Last First Occupation

DOB: ____________________ Employer: _________________________ Home #: _____________________
Cell #: ____________________ Work #: __________________________ E-mail: ______________________
SS# ______________________ DRIVERS LICENSE # _______________________

Insurance Information

Insured's Name: ________________________________ Insurance Co.:_____________________________________
ID # FOR INS __________________________________ Insured's Employer: __________________________________

Current Dental Habits

1. Has your child been seen by another dentist/dental professional since their last visit with us? Yes No
   If yes, with whom and when was the last visit? ____
   What was the reason for the visit? ____
2. How often does your child brush his/her teeth? ____
3. Does your child floss? Yes No
4. Do you live in an area **without** fluoridated water? Yes No
5. Does your child drink water from? City Bottled Well
6. Do you cook with water from? City Bottled Well
7. Does your child use a Fluoride rinse? I.E. ACT? Yes No

Medical History Updates

1. Is your child being treated by a physician at this time? Yes No
   If yes, who is the physician and what is the reason for the treatment? ____

2. Have you ever been told your child requires **Antibiotic pre-medication** prior to a dental appointment? Yes No
   If so, why? ____

3. Is your child taking any medication (prescription or over the counter, including Tylenol, Advil, Vitamins, Birth Control Pills), vitamins, or dietary supplement? Yes No
   List the name, dose, frequency and date started ____
   ____
   ____
4. Has your child had any illness, surgery, injury, allergic reaction, or medical emergency in the past year? Yes No
   Please describe ____
5. Has your child ever had a reaction to or problem with an anesthetic? Yes No
   Please describe ____
6. Has your child ever had a **reaction or allergy to an antibiotic, sedative, or other medication**? Yes No
   Please list ____
7. Is your child **allergic to latex** or anything else such as metals, acrylic, or dye? Yes No
   Please describe ____
8. Have there recently been any significant changes/disruptions to your child's family, home or school routines? Yes No
   Please describe ____
9. What is your primary concern regarding your child's oral health? ____
10. Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office? Yes No
    Please describe ____
11. Has your child's diet changed significantly since his/her last dental visit? Yes No
    Please describe ____
12. Is there any other change in the child's medical, dental, or family history that the dentist should be aware of? Yes No
    Please describe ____

13. Who is your child's Pediatrician? _____________________________________Date of Last Check-up? ________________

14. For female adolescents
    a. Has your child begun menses? Yes No

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 of confidence and that it is my responsibility to inform this office of any changes to my child's medical status. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may at the discretion of this office, use the services of one or more credit reporting services.

I authorize the dental staff to perform the necessary dental services my child may need.

____ ____________________________ ______________
Signature of Parent/Guardian Relationship to Patient Date

*** The Parent or Guardian who accompanies the child is responsible for payment. ***

I have reviewed the health questionnaire with the child's parent/guardian.

Signature of Dentist Date