Medical History Update

Child's Name:____ Date:_____________________

Child's Date of Birth: _______________________________________

Is your child currently in braces? Yes________ No________

Has your insurance changed since your last visit? Yes_____ No_____ (If new, please provide information)

Has your child had any changes in their medical history?

Yes________ No_________ If so, what?____

Please list any medications that your child is currently taking.

____

Is your child allergic to any medications?

Yes________ No_________ If so, what?____

Please list any allergies that your child may have.

____

Has there been any change to your contact information? _____Yes (complete below) _____No

Home address: ____

____

Phone Number:____

Email Address:____

A typical preventative or "cleaning" visit consists of:

- **An Examination**
- **A Prophylaxis or "Cleaning"**
- **A Fluoride Treatment**
- **And Radiographs/X-rays (as recommended)**

Some insurance companies will cover all of these recommended procedures at each 6 month visit, while others will cover certain procedures only once per year.

_____I would like my child to have all recommended procedures and understand that I will be responsible for any fees not covered by my insurance.

_____I would like my child to have only those procedures covered by my insurance. I understand that without recommended x-rays, the dentist cannot fully diagnose cavities or periodontal disease. I also understand that professionally applied Fluoride is strongly recommended twice a year for the prevention of cavities.

If you are self pay, please inform us if there are any recommended procedures that you do not want completed today.

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS UPDATE HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY CHILD'S HEALTH AND THAT IT IS MY RESPONSIBILITY TO INFORM THE STAFF OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS. I ALSO AUTHORIZE THE STAFF TO PREFORM ANY NECESSARY DENTAL SERVICE THAT MY CHILD MAY NEED.

SIGNATURE:____Date:_____________________

PRINT NAME:___________________________________ Relationship to Patient:_____________________