HEALTH INFORMATION UPDATE

Dear Parents:

To ensure that we have up-to-date medical information, we are required to obtain the following information ***every six months*** or sooner if a major medical change has taken place. Thank you for taking the time to answer the following questions.

Child's Name: ________________________________DOB: ______________Age:____________
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Address:_____________________________________ Apt: _____________
City:________________________State:___________ Zip:_____________
Parent's Name:_____________________________E-mail__________________________________
Home phone #:____________________________Cell phone #:_____________________________

☐***Check here there if NO Change of Medical History, Allergies, or Medications***

1. Name of **physician** and phone number:____

2. Has your child's **medical history** changed since your last visit? ____________________________
If yes, please explain: ____

3. Is your child taking any **medication** at the present time? ___________________________________
If yes, please explain: ____

4. Is your child **currently undergoing** any medical treatment? _______________________________
If yes, please explain: ____

5. Does your child have any **heart** related conditions [ex. Heart murmur]? ______________________
If yes, please explain: ____

6. Does your child have any **health problems** that need further clarification? ___________________
If yes, please explain: ____

7. Is your child **allergic** to any medications, dyes, food, flavors or LATEX? ____________________
If yes, please list: ____

8. Has your child had any **injuries/accidents** involving the head, face, or teeth
Since our last visit? ____

9. Are there any **dental related questions** that need to be discussed with the Dentist?
____

10. Have there been any **CHANGES to your insurance** since your last visit? IF YES, please furnish a copy of the insurance card. Insurance Co: _______________________________________
Subscriber ID#:_____________________________ Group # ___________________________
Name of Employer: __________________________ Ins Phone#________________________

Parent Signature: ______________________________ Relationship to patient: _________________

Date: _____________________ Doctor's Signature: _____________________________________