Children's Dental Health of Lynchburg
Specializing in Children, Teens, and Young Adults

SHANNON SAWYER, D.M.D SUMMER SAWYER, D.M.D

MEDICAL HISTORY UPDATE

Child's Name_____ Date:_____

Full Address_____

Telephone (h)_____ Cell Phone_____

Email_____

***Please let us know your preferred method of contact on how you wish to be notified of appointments**

☐ *Text Message to cell phone* ☐ *Email*
☐ *Voice Message to cell phone* ☐ *Voice Message to home phone*

1. Have there been any changes in your child's medical history since your last visit? **Yes / No**
   If yes, please explain:_____
2. List any medications your child is now taking:
   _____
3. **Female patients only**. To your knowledge, is there any chance your child is pregnant? **Yes / No**
4. Have there been any dental concerns since your last visit? **Yes / No**
   If yes, please explain: _____
5. If needed, do you have any objection to dental x-rays being taken today? **Yes / No**
6. Would you like sealants (cavity protectors) on your child's permanent molars if insurance covers the treatment 100%? (*Note: your child must be at least 5 years old)* **Yes / No**
7. Have there been any insurance changes since your last visit? **Yes / No**
   If yes, please give your insurance card to our front desk so we may get a copy
8. Would you like to speak with the doctor after your child's dental visit?
   ____ YES ____ NO _____ IF NECESSARY

Print name: _____ Your relationship to child: _____

Signature: _____