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

MEDICAL HISTORY UPDATE

Child's Full Name_____ Age: _____ Today's Date:_____

Full Address_____

Telephone (h)_____ Cell Phone_____

Email_____

***Please let us know how you wish to be notified of appointments (please check all that apply)**

☐ *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:_____
   Female patients only. To your knowledge, is there any chance your child is pregnant? **Yes** **No**

2. List any medications your child is now taking:
   _____

3. Does your child have any allergies? **Yes** **No**
   If yes, please list:_____

4. Have there been any dental concerns since your last visit? **Yes** **No**
   If yes, please explain: _____

5. Would you like sealants (cavity protectors) on your child's permanent molars if insurance covers the treatment? *(Note: your child must be at least 5 years old)* **Yes** **No**

6. 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

I understand that today's visit is for a comprehensive dental examination, cleaning, fluoride, and x-rays (if needed).

This office follows the guidelines of the American Academy of Pediatric Dentistry and recommends x-rays taken every 1-2 years. Current x-rays are necessary for a comprehensive dental examination. No restorative work will be scheduled without current x-rays. No exceptions.

Print name: _____ Your relationship to child: _____

Signature: _____

Missed Appointment Policy: I understand that I am required to provide a 24-hour cancellation notice. First failed appointment may result in a $35 fee. Second failed appointment within a 12-month period may lead to dismissal from the practice.

Signature:_____