



MEDICAL HISTORY UPDATE

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

Full Address _____

Telephone (h) _____ Cell Phone _____

Email _____

**** Our office uses phone, text and emails as a way to remind you of future appointments. Be sure to provide the phone number you would like the reminders sent to.****

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: _____