

MEDICAL HISTORY UPDATE

PATIENT NAME	MOM HOME PHONE
	DAD HOME PHONE

DATE _____

Has there been any change in your child's health since your last dental appointment? YES NO
For what conditions? _____

Is your child taking any kind of medication at this time? YES NO
If so, what _____

Does your child have any allergies (or adverse reactions) to any medications? YES NO
If so, what _____

PARENT SIGNATURE

PLEASE UPDATE THE FOLLOWING:

Home Address: _____

Mom Work Phone: _____ Dad Work Phone: _____

Mom Cell Phone: _____ Dad Cell Phone: _____

Mom Email Address: _____ Dad Email Address: _____

INSURANCE INFORMATION: Any Changes? YES NO

IF YES, PLEASE FILL OUT THE FOLLOWING:

Insured's Name _____

SS# _____

Employer _____

Insurance Company Name _____

Address _____

Group # _____

Phone # _____