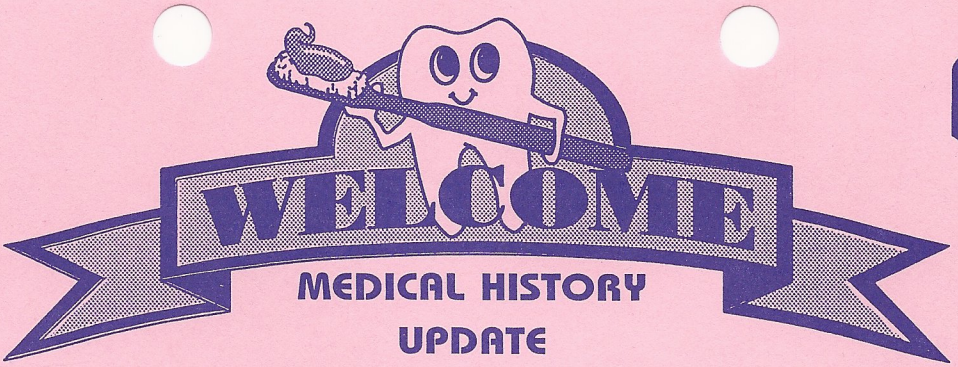

MEDICAL HISTORY UPDATE

Pediatric DENTAL CENTER

Date _____

1

To assist us in keeping your child's medical history up to date, and for computer purposes, would you please answer the following questions:

_____ CHILD'S NAME _____ HOME NUMBER AGE _____ ☐ MALE ☐ FEMALE

_____ ADDRESS _____ CITY ST ZIP

_____ FATHERS' NAME _____ MOTHERS' NAME

_____ EMAIL _____ EMAIL

_____ EMPLOYER _____ EMPLOYER

_____ BUSINESS ADDR. & PHONE _____ BUSINESS ADDR. & PHONE

_____ DATE OF BIRTH/S.S. # _____ DATE OF BIRTH/S.S. #

2

	YES	NO
1. Has your child's medical history changed since your last visit to this office?	❒	❒
If yes, please explain _____		
2. Is your child taking any medication at the present time?	❒	❒
If yes, please explain _____		
3. Has your child been in the hospital in the last year?	❒	❒
If yes, please explain _____		
4. Is there anything you feel we should know about your child's health history?	❒	❒
If yes, please explain _____		

5. What do you like most about your treatment in our office? _____

_____

6. What would you suggest to improve our service in the future? _____

_____

3

Do you have dental insurance? ❒ Yes ❒ No

Which parent is the primary insurance carrier? ❒ Father ❒ Mother

Insurance Company _____

Insurance Company's Address _____

City _____ State _____ Zip _____

Group # _____ Policy # _____ Local # _____ Union # _____ Claim # _____

PARENT OR GUARDIAN SIGNATURE _____