



MEDICAL/ DENTAL HISTORY/CONTACT UPDATE

(Required Every 6 Months)

CHILDS NAME _____ DOB _____

ADDRESS (Parent/Guardian) _____

CITY _____ STATE _____ ZIP CODE _____

HOME # _____ CP# _____ WORK# _____

EMAIL _____

DO YOU HAVE ANY CONCERNS/QUESTIONS ABOUT YOUR CHILDS DENTAL HEALTH THAT WE CAN ANSWER TODAY?

****Any Allergies?** _____

In order to keep your child's record up to date and accurate, Please CIRCLE any changes since the last six months and note below to explain/clarify:

Home address

Phone number

Parent's marital status

Financial responsibility

Dental insurance

medical condition

heart murmur

current medicines

hospitalization

allergies

oral habits

speech therapy

stained teeth

broken teeth

crooked teeth

Parents name behavior problems mouth sores/ulcers

SIGNATURE PARENT/GUARDIAN _____

RELATIONSHIP TO CHILD _____

TODAYS DATE _____

FOR THE SAFETY OF OUR PATIENTS AND YOUR CHILD, WE REQUIRE MEDICAL HISTORY UPDATES

THANK YOU FOR YOUR TIME