INFORMATION UPDATE

Patient Name: _____ Patient D.O.B.: _____

Parent or Guardian Information

Last Name: _____ **First Name**: _____ **M.I.**: _____

Relationship to child: ☐ **Father** ☐ **Mother** ☐ **Stepfather** ☐ **Stepmother** ☐ **Legal Guardian** ☐ **Temporary Custodian**

D.O.B.: _____ **S.S.#**: _____ **Drivers License#**: _____

Address: _____ **City, State, Zip**: _____

Home Phone: _____ **Cell Phone**: _____ **Employer**: _____ **Employer Phone**:_____

Does your insurance cover your child's dental care? **YES** or **NO**

Dental Insurance Carrier_____ **Ins. Phone**: _____ **Ins. I.D.#:**

Last Name: _____ **First Name**: _____ **M.I.**: _____

Relationship to child: ☐ **Father** ☐ **Mother** ☐ **Stepfather** ☐ **Stepmother** ☐ **Legal Guardian** ☐ **Temporary Custodian**

D.O.B.: _____ **S.S.#**: _____ **Drivers License#**: _____

Address: _____ **City, State, Zip**: _____

Home Phone: _____ **Cell Phone**: _____ **Employer**: _____ **Employer Phone**:_____

Does your insurance cover your child's dental care? **YES** or **NO**

Dental Insurance Carrier_____ **Ins. Phone**: _____ **Ins. I.D.#:**

Does your child have any new allergies? **YES** or **NO**
If yes, please explain:

_____

_____

_____

Is your child currently seeing an orthodontist? If yes, who?

_____

DAYTON PEDIATRIC DENTISTRY
DENTISTRY FOR CHILDREN AND ADOLESCENTS

Parent/Guardian Signature: _____

Date: _____

→

Medical History Update

Child's Name: _____ DOB: _____

Child's Family Physician _____ Phone _____
Address _____
Is your child in good health? **Yes** or **No** If no, please describe _____
Were there any problems at birth? **Yes** or **No** If yes, please describe _____
Are your child's immunizations and booster shots up to date? **Yes** or **No**
Has your child ever been allergic to anything? **Yes** or **No**
If yes, what was the food or drug? _____ Reaction _____
Has your child had any surgical operations? **Yes** or **No**
If yes, for what? _____
Has your child ever been hospitalized? **Yes** or **No**
If yes, for what? _____

Has your child had or does he/she now have any of the following? ***PLEASE CIRCLE YOUR ANSWER***

Allergies/ Sinus problems/ drainage	**Yes or No**	Eating disorders	**Yes or No**	Steroid therapy or chemotherapy	**Yes or No**
Asthma	**Yes or No**	Abnormal bleeding/bruising	**Yes or No**	Nervous or mental disorders	**Yes or No**
Heart trouble or heart murmur	**Yes or No**	Blood transfusions	**Yes or No**	Convulsions or seizures	**Yes or No**
Rheumatic heart disease or fever	**Yes or No**	Birth defects	**Yes or No**	Frequent diarrhea or vomiting	**Yes or No**
Blood diseases or anemia	**Yes or No**	Kidney disease	**Yes or No**	Mumps, measles, or chicken pox	**Yes or No**
AIDS virus	**Yes or No**	Cleft lip or palate	**Yes or No**	Cancer, tumors, growths, or cysts	**Yes or No**
Herpes virus or shingles	**Yes or No**	Scarlet fever or high fever	**Yes or No**	Tuberculosis or TB exposure	**Yes or No**
Diabetes	**Yes or No**	High or low blood pressure	**Yes or No**	Problems with anesthesia	**Yes or No**
Ear, eye, nose or throat trouble	**Yes or No**	Liver disease	**Yes or No**	Thyroid disease	**Yes or No**
Stomach ulcers	**Yes or No**	Jaundice or hepatitis	**Yes or No**	Down's Syndrome	**Yes or No**
Austism/Asperger's/PDD/NOD	**Yes or No**	Developmental Delays	**Yes or No**		

*** If yes, please specify

_____
_____

Current Medications:

Name/Strength (mg)	How often?	Reason for taking?

Social History:

Do you consider your child to be □ advanced in learning □ progressing normally □ a slow learner
Child's first language _____ Second or other languages _____
Child's favorites (pet, toy, color, hobby, etc.) _____
How does your child tolerate dental/medical care? _____

Authorization and Release:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release information, including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care to other healthcare practitioners.

Signature of Parent/Guardian _____ Date_____
Printed Name _____
Doctor's Signature _____ Date _____