Existing Patient Information Update

FAMILY INFORMATION (please print)

1. Child Name _____
2. Who brought child today? _____ Relationship to patient _____
3. Does child live with: (circle one) Mom Dad Both Parents Guardian
4. How would you prefer to be contacted? (Circle one) Phone, Text, or E-mail _____
5. Please list any additional person who you would allow to bring your child to the dental appointment, or who you would let have access to your child's health information or dental records.

_____

_____

By signing below, I understand that I am giving any additional person listed, the same responsibility to relay any information from the appointment to myself and/or spouse.

DOES YOUR CHILD'S DENTAL HISTORY INCLUDE ANY OF THE FOLLOWING:

1. Has your child been seen in another office since your last visit with us? **YES NO**
   If **YES**, was the visit a good or poor experience: _____
2. Does your child have pain/discomfort with teeth or gums? **YES NO**
3. Do you suspect that your child might have cavities? **YES NO**
4. Are you concerned about any orthodontic problems? **YES NO**
5. Do you have questions about preventive dental procedures? **YES NO**
6. Does your child swallow fluoride supplements daily? **YES NO**

DOES YOUR CHILD'S MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING:

1. Approximate date of your child's last **medical** examination? _____
2. Is your child under the care of a physician? **YES NO**
   If YES EXPLAIN _____
3. Does your child have a history of rheumatic fever, heart murmur or heart trouble? **YES NO**
4. Does your child or any immediate family member have history of diabetes? **YES NO**
   IF YES, LIST FAMILY MEMBER: _____
5. Does your child have a history of kidney or liver disease? **YES NO**
6. Does your child have a history of epilepsy or nervous system disorder? **YES NO**
7. Does your child have a history of tuberculosis? **YES NO**
8. Does your child have a history of asthma or lung problems? **YES NO**
9. Does your child have history of bleeding disorders, blood transfusions or aids? **YES NO**
10. Does your child have a history of hepatitis? **YES NO Type?** _____
11. Does your child have any Physical, Mental or Emotional Handicaps, ADHD ? **YES NO**
12. Does your child have allergic reactions to latex, drugs, etc.? **YES NO**
    If YES which ones: _____
13. Due to X-Rays reasons is your child pregnant? **YES NO**

PLEASE LIST ALL MEDICATIONS YOUR CHILD IS CURRENTLY TAKING:

_____ _____

_____ _____

X _____ **DATE** _____

PARENT OR GUARDIAN SIGNATURE