Health History Update

Date: _____

Child's Name: _____

Parent's Cell Phone Number: _____

Parent's Email Address: _____

NEW Address and Phone Number: _____

_____

*****Please give front desk your current insurance card and driver's license*****

1. Is there anything about your child's teeth, mouth or jaw that concerns you? Y or N

If Yes, what? _____

2. Is your child currently under the care of a physician for any medical problems? Y or N

If Yes, what? _____

3. Are immunizations, including tetanus, up to date? Y or N

4. Date of your child's last physical examination. _____

5. Does your child have a heart condition that requires antibiotics prior to dental treatment? Y or N

6. Is your child allergic to any medications? Y or N

If Yes, what? _____

7. Is your child taking any medications? Y or N

If Yes, what? _____

8. Is your child allergic to latex, metals or acrylics? Y or N

If Yes, what? _____

9. Do you use well water? Y or N

10. Do you use bottled water? Y or N

If Yes, is it fluoridated? Y or N

We care about your child's dental health!! How firm do you want us to be with their oral hygiene and nutritional counseling?

____ Gentle ____Moderate ____Firm