Medical History Update

Patient Information

Child's Name: _____
Last First MI Preferred Name

Date of Birth: _____ Child's Social Security #: _____

Preferred contact number: _____ Preferred E-mail: _____

Current Insurance Company: _____

Medical History

Child's pediatrician: _____ Phone Number: _____

Date of last visit: _____

Has your child been hospitalized or had surgery in the last 2 years? ☐Yes ☐No

If Yes, please explain: _____

Does your child have any special needs? ☐Yes ☐No Please list: _____

Any other medical conditions or concerns? _____

For patients 14 and over: Any recreational use of tobacco, alcohol or history of substance abuse?

☐Yes ☐No **If yes, please provide additional details:**

_____

For ALL patients, has your child ever had any of the following? (<u>Please select yes or no for each condition</u>)

Abnormal Bleeding	☐Yes ☐No	Kidney Disorder	☐Yes ☐No
ADD/ADHD	☐Yes ☐No	Learning Disabilities	☐Yes ☐No
AIDS/HIV	☐Yes ☐No	Liver Problems	☐Yes ☐No
Anemia	☐Yes ☐No	Lung Disease	☐Yes ☐No
Asperger's	☐Yes ☐No	Mental/Emotional Disorder	☐Yes ☐No
Asthma	☐Yes ☐No	Muscular Dystrophy	☐Yes ☐No
Autism	☐Yes ☐No	Nose/Throat Disorder	☐Yes ☐No
Cancer/Tumors	☐Yes ☐No	Premed Needed	☐Yes ☐No
Cerebral Palsy	☐Yes ☐No	History of RSV	☐Yes ☐No
Cleft Lip/Palate	☐Yes ☐No	Respiratory Problems	☐Yes ☐No
Diabetes	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Downs Syndrome	☐Yes ☐No	Sickle Cell Trait	☐Yes ☐No
Epilepsy/Convulsions/Seizures	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Hearing Impaired	☐Yes ☐No	Speech Problems	☐Yes ☐No
Hemophilia	☐Yes ☐No	Stomach problems/ Disorder	☐Yes ☐No
Hepatitis	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Heart Condition/Murmur	☐Yes ☐No	Tuberculosis	☐Yes ☐No
		Vision Problems	☐Yes ☐No

If any yes answers above please explain or give additional details: _____

_____

Please list all current medications-prescription, non-prescription and supplements. _____

_____

Allergies

☐None ☐ Penicillin/Amoxicillin ☐Codeine ☐Latex ☐ Ibuprofen ☐Anesthetic

☐Other (Please list): _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I am the parent, guardian or personal representative of this patient and have the legal right to authorize medical and dental care for this child. 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 or dental status. I authorize the dentist and staff of Center For Pediatric Dentistry to perform the necessary dental services my child may need. I also authorize the dentist and staff of Center For Pediatric Dentistry to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications. I request that my insurance company pay directly to the dentist. I agree to remain on the premises while my child is being treated. I understand that my insurance carrier may pay less that the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf. I also agree that any fees incurred on this account for finance charges, collection actions or delayed payment by myself or the insurance company will be my responsibility.

Signature of Parent/Guardian: _____Date:_____

Printed Name of person signing: _____ Relationship to patient: _____

Does this person have the legal right to make health care decisions for the patient listed above? ☐Yes ☐No

Reviewed and signed by Dr: _____ Date: _____