FIRST CLASS PEDIATRIC DENTISTRY

Update Form

Your Child's Information ___ Male ___ Female

Last Name: First Name: Birthdate:

Cellular Telephone Number: _____ E-mail: _____

Home Telephone Number: _____ Work Telephone Number: _____

Address: _____ City, State, ZIP: _____

General Information

Who is accompanying the child today? _____

What is your date of birth? _____ What is your relation to this child? _____

INSURANCE INFORMATION

(Complete if the information is different from previous visit)

Name of Insured: _____ Insurance Company Name: _____

Insurance Company Address: _____

City: _____ Group # _____

Union/Local/Policy # _____ Deductible: _____ Max annual benefit: _____

PLEASE MARK "Y" FOR YES OF "N' FOR NO AS IT RELATES TO YOUR CHILD'S HEALTH

Does your child have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Heart Murmur	☐	☐	Hemophilia/Bleeding problems/ Anemia
☐	☐	Shunts	☐	☐	Hearing Impairment
☐	☐	Cancer	☐	☐	Speech Issues
☐	☐	Diabetes	☐	☐	ADD/ADHD/Hyperactive
☐	☐	Rheumatic Fever	☐	☐	Frequent Headaches
☐	☐	Liver Problems/ Hepatitis	☐	☐	Asthma/ Last attack _____
☐	☐	Kidney Disease	☐	☐	Convulsions/ Epilepsy/ Seizures
☐	☐	HIV Positive	☐	☐	Pregnant
☐	☐	Physical/Mental Impairment	☐	☐	Learning Disability/ Developmental Delay
☐	☐	Personality/ Social Disorder	☐	☐	Dermatologic or Skin Conditions
☐	☐	Autism			

Does your child require antibiotics prior to dental visits? Y/N _____

Does your child have any prosthetics? (Example: artificial limbs, prosthetic eye, pins, screws, etc.) Y/N _____

Any other medical problems relates to this child? If yes please list: _____

DENTAL/MEDICAL HISTORY

List ANY medications (prescriptions/ non-prescription) that your child currently takes:

_____

Does your child any allergies to medications or materials including latex?

_____

Please describe any surgeries or hospitaliztions that your child has had:

_____

Please elaborate on any concerns that you have about your child's mouth:

_____

The information I have given is correct to the best of my knowledge and I understand that it will be held in the strictest of confidence. I also understand that it is my responsibility to inform this office of any changes in my child's medical status, address, phone number, e-mail address or other personal information. I give Children's Dentistry of Lithonia, LLC permission to perform cleanings, x-rays, exams, and flouride treatments, sealants (with prior authorization), emergency treatment for my child.

Signature of parent/ guardian _____ Date: _____