Pediatric dental arts home

making your child's smile a work of art!

Health History Update

Patient's Name: _____
Date of Birth: _____

1. Has your address, phone number or email changed? Yes/No
   If yes: _____

2. Has your insurance changed? Yes/No ***If yes, please inform us immediately****
   If yes: _____

3. Please check box for preferred office communication.
Text [ ] _____Email [ ] _____Phone Call [ ] _____

4. Has your child had any health changes since their last visit? Yes/No
   If yes, please explain: _____

5. Is your child taking any medications (prescription, over-the-counter, vitamin supplements)? Yes/No
   If yes, please list the following:
   Medication: _____ Reason: _____
   Medication: _____ Reason: _____
   Medication: _____ Reason: _____

6. Is your child allergic to (please explain if yes to any)... Yes/No
   - Any medications? _____
   - Any foods? _____
   - Other? _____

7. Has your child been hospitalized or had surgery? Yes/No
   If yes, please explain: _____

8. Is your child experiencing any of the following - dry cough, runny nose, sore throat, watery eyes, sinus pain/pressure that is unusual and not related to seasonal allergies, headaches, fatigue, weakness, loss of taste and/or smell? Yes/No
If yes, please explain: _____

9. I consent to the administration of fluoride treatment. Yes/No

10. I consent to radiographs (x-rays). Yes/No
I am aware that if I continue to refuse radiographs in the future, my child may be dismissed from the practice.

11. Any dental concerns or comments? Yes/No
    If yes, please explain: _____

Parent Signature: As this child's parent or legal guardian, I acknowledge that the information I have given is correct to the best of my knowledge. I understand that misrepresenting or withholding medical/dental information can be harmful to my child during treatment.

Please print full name: _____ Today's date: _____

Parent or legal guardian's signature: _____