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. Women: Do you suspect that you are pregnant? Yes/No Due Date: ____________________

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

11. 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.

12. 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: ____________________