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Medical and Dental History Update

Patient's Name: _____ Date of Birth: _____

Name of Physician (PCP): _____ **Phone**: _____

Have there been any changes in your child's medical history since their last visit? [ ]Yes [ ]No
If yes, please explain _____

Has your child seen a physician since their last visit ? [ ]Yes [ ]No
If yes, please explain _____

Is your child taking any medications (over-the- counter or prescription) at the present time? [ ]Yes [ ]No
If yes, please explain _____

Does your child have any allergies? (Medications, food, seasonal, latex, etc.) [ ]Yes [ ]No
If yes, please explain _____

Has your child experienced an injury to the head or neck since their last visit? [ ]Yes [ ]No
If yes, please explain _____

Does your child have a dental problem that concerns you? [ ]Yes [ ]No
If yes, please explain _____

***Some insurance companies cover topical fluoride treatment only once a year and have age limitations. Topical Fluoride application is recommended every 6 months to help keep the tooth's enamel surface cavity resistant.**

- **I ACCEPT ( ) DECLINE ( ) FLUORIDE TREATMENT FOR TODAY'S APPOINTMENT.**

***RADIOGRAPHS ARE RECOMMENDED AND USED FOR CAVITY DETECTION EVERY 12 MONTHS.**

- **I ACCEPT ( ) DECLINE ( ) RADIOGRAPHS FOR TODAY'S APPOINTMENT.**

Signature of parent / guardian (or patient if over 18 years of age) Relationship to patient Date