HEALTH HISTORY UPDATE

PATIENT'S NAME: _____ DATE: _____
Email: _____
Phone number 1: _____ Address : _____
Phone number 2: _____
Check box if no changes to above section: ☐

Is your child currently taking any medications or under medical care? If so, please explain: _____
Any recent surgeries? _____ Name of Physician or specialist: _____
Recent illness or injuries? _____
Has your child had any unfavorable reactions to drugs, including antibiotics or local anesthetic solutions? _____

Does your child have, or had the following: Please CIRCLE
Hepatitis Heart Disorder Heart Murmur Blood Pressure (high, low) Seizure Disorder Rheumatic Fever Acid Reflux (GERD) Liver Disorder
Blood Disorder Kidney Disorder Asthma Jaw Problems Implants HIV Thyroid Diabetes Celiac Disease Hypoglycemia Anemia
Tobacco/Vaping Cancer Speech Issues Hearing Disorder Vision Developmental Delay Gluten Intolerance
Behavioral Issues Sensory ADHD ADD Autism Spectrum Disorders Other: _____

Allergies to any of the following: Please Circle
Bananas, Chestnuts, Tree nuts, Avocados, Kiwis, dyes, Dairy, Seasonal, Latex
Check box if no changes to above section: ☐

DENTAL INSURANCE UPDATE

Primary Dental Insurance
Name of Insured _____
Relationship _____
Soc Sec # _____ DOB_____
Employer _____
Insurance Co _____
ID Number _____

Secondary Dental Insurance
Name of Insured _____
Relationship _____
Soc Sec # _____ DOB_____
Employer _____
Insurance Co _____
ID Number _____

Check box if no changes to above section: ☐

SIGNATURE: _____ relationship: _____
(under 18 must be signed by parent/guardian)