



## MEDICAL / DENTAL HISTORY UPDATE

(FOR THE SAFETY OF OUR PATIENTS, WE REQUIRE A MEDICAL HISTORY UPDATE EVERY 6 MONTHS)

CHILDS NAME \_\_\_\_\_ DOB \_\_\_\_\_

DO YOU HAVE ANY CONCERNS/QUESTIONS ABOUT YOUR CHILD'S DENTAL HEALTH THAT WE CAN ANSWER TODAY?

\_\_\_\_\_

ANY ALLERGIES? \_\_\_\_\_

IN ORDER TO KEEP YOUR CHILD'S RECORD UP TO DATE AND ACCURATE, PLEASE CHECK OFF ANY CHANGES AND NOTE BELOW TO EXPLAIN:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> PARENTS MARITAL STATUS PARENT'S NAME | <input type="checkbox"/> DENTAL INSURANCE  | <input type="checkbox"/> STAINED TEETH        |
| <input type="checkbox"/> FINANCIAL RESPONSIBILITY             | <input type="checkbox"/> MEDICAL CONDITION | <input type="checkbox"/> HOSPITALIZATION      |
| <input type="checkbox"/> HOME ADDRESS                         | <input type="checkbox"/> ORAL HABITS       | <input type="checkbox"/> BROKEN TEETH         |
| <input type="checkbox"/> PHONE NUMBERS / EMAIL ADDRESS        | <input type="checkbox"/> HEART MURMUR      | <input type="checkbox"/> CROOKED TEETH        |
|   | <input type="checkbox"/> SPEECH THERAPY    | <input type="checkbox"/> BEHAVIOR PROBLEMS    |
|   | <input type="checkbox"/> CURRENT MEDICINES | <input type="checkbox"/> MOUTH SORES / ULCERS |

\_\_\_\_\_

In an effort to improve communications with our patients, Pediatric Dental Healthcare will be E-mailing and texting appointment reminders in the future. If you are interested in being part of this service when it becomes available, please enter your information below. We do not share or sell personal information to any third parties.

E-mail: \_\_\_\_\_ Mobile Phone#: \_\_\_\_\_  
(Please Print Clearly) (Your Phone Provider May Charge a Texting Fee)

### INFORMED CONSENT FOR PARENTS/GUARDIANS ACCOMPANYING THE CHILD

I hereby authorize the dentists and staff at Pediatric Dental Healthcare to perform diagnostic aids including an examination, x-rays, photographs, models, cleaning and fluoride treatment, as the standard of care to properly diagnose and record any and all dental conditions. *(Please cross out any treatment that you do not want performed.)*

I authorize my insurance company to pay Pediatric Dental Healthcare all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance, all broken appointment fees and all late payment service charges. I also understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of Pediatric Dental Healthcare. This consent is to remain in effect from the date indicated until cancelled in writing.

SIGNATURE \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_ DATE \_\_\_\_\_