Patient Update 2019:

Contact Information-

Patient Name: _____ D.O.B:_____ Gender: _____

No Address or Contact Information Changes ☐

Address: _____ City: _____

State: _____ Zip: _____Home #:_____

Primary Cell #: _____ Secondary Cell #: _____

Email: _____

Medical Information-

Does your child have any of the following medical problems?

Circle Y or N

Y N Abnormal Bleeding	Y N Cancer	Y N Kidney Disease
Y N ADD	Y N Chicken Pox	Y N Liver Disease
Y N ADHD	Y N Congenital Heart Defect	Y N Measles
Y N AIDS / HIV	Y N Convulsions	Y N Mononucleosis
Y N Exposed to HIV, but Neg?	Y N Depression	Y N O.C.D.
Y N Anemia	Y N Diabetes	Y N Rheumatic Fever
Y N Anxiety	Y N Epilepsy/Seizures	Y N Scarlett Fever
Y N Artificial Bones	Y N Gastric Reflux	Y N Sensory Issues
Y N Artificial Joints	Y N Handicaps/ Disabilities	Y N Sickle Cell Disease/Traits
Y N Artificial Valves	Y N Hearing Loss	Y N Skin Rash/Hives
Y N Asthma	Y N Heart Murmur	Y N Sleep Apnea
Y N Asperger's	Y N Hemophilia	Y N Tuberculosis (TB)
Y N Autism	Y N Hepatitis	Y N Vision Loss
Y N Broken Bones	Y N Intestinal Problems	

If yes, please explain: _____

Has your child had *any* **medical issues, surgeries** or **hospital stays** since their last dental visit?
(YES / NO)
If **YES**, please explain:

_____

Does your child have **any** allergies? **(YES / NO)**
If **YES**, please explain:

_____

Does your child ***take*** **any medications/ vitamins/ supplements/ hormones? (YES /NO)**
If **YES**, please list here:

_____

Parent/ Guardian Signature: _____ Date: _____