Antioch Brentwood Pediatric Dentistry

PATIENT UPDATE FORM

THE INFORMATION YOU INCLUDE ENABLES US TO PROVIDE BETTER CARE FOR YOUR CHILD

CHILD'S NAME _____
DATE OF LAST PHYSICAL_____ MEDICAL DR.'S NAME_____
ALLERGIES TO MEDICATIONS OR DRUGS? YES / NO (LIST IF ANY) _____
LIST ALL CURRENT MEDICATIONS: _____
CURRENT HEALTH STATUS AND/OR DIAGNOSIS:_____
SERIOUS INJURY OR HOSPITALIZATION? YES / NO (IF YES) _____
SURGERY OR TRANSFUSION? YES / NO (IF YES) _____
ANY INJURIES TO TEETH, HEAD, OR NECK? YES / NO (IF YES)_____
ANY SIGNIFICANT FAMILY OR BEHAVIORAL CHANGES? YES / NO (IF YES) _____
HAS THE PATIENT BEEN SEEN BY ANY OTHER DENTAL PROVIDER IN THE PAST 6 MONTHS? YES / NO
(IF YES) _____
BOTTLED WATER _____ TAP WATER _____ FLUORIDE TABLETS _____WATER FILTER_____

NOTE ANY CHANGES IN THE FOLLOWING:
HOME ADDRESS _____ EMAIL _____
HOME PHONE _____ MOBILE_____
DENTAL INSURANCE _____GROUP#_____
NAME OF INSURED _____ EMPLOYER _____
INTERESTED IN APPOINTMENT INFORMATION VIA TEXT OR EMAIL? _____

FOR TODAY'S APPOINTMENT:
PERMISSION TO TAKE XRAYS IF NECESSARY: YES / NO
FLUORIDE VARNISH APPLICATION: YES / NO

PLEASE PROVIDE BUSINESS AND/OR MOBILE PHONE NUMBERS FOR THE FOLLOWING:
MOTHER_____FATHER_____
SIGNATURE_____RELATIONSHIP TO CHILD_____ DATE_____

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