

HEALTH HISTORY UPDATE

ACCOUNT # _____

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 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

Secondary Dental Insurance

Name of Insured _____

Name of Insured _____

Relationship _____

Relationship _____

Soc Sec # _____ DOB _____

Soc Sec # _____ DOB _____

Employer _____

Employer _____

Insurance Co _____

Insurance Co _____

ID Number _____

ID Number _____

Check box if no changes to above section:

SIGNATURE: _____ relationship: _____

(under 18 must be signed by parent/guardian)