Health History Update

Today's Date: _____

Patient's Name: _____ DOB: ___/___/_____
Address: _____
Home: ( )_____ Work: ( )_____ Cell: ( )_____Confirmation Texts? Y N
Email Address: _____ Account Responsible Party: _____
Insurance Company: _____ Employer: _____
Policy Holder: _____ DOB ___/___/_____
Group Number: _____ Subscriber ID: _____

Has patient seen another dentist since last visit in our office? YES NO
If so, dentist's name: _____ Phone: ( )_____
Reason for visit: _____ X-rays Taken? YES NO
Does the patient brush daily? YES NO Does the patient floss daily? YES NO
Does the patient take fluoride supplements? YES NO Jaw Problems? YES NO
Does the patient have any of the following habits?

Lip Sucking/Biting	Y N	Thumb/Finger Sucking	Y N
Nursing Bottle Habits	Y N	Nail Biting	Y N

Do you have any major dental concerns?
_____

Has the patient ever had any of the following medical conditions?

Abnormal Bleeding	Y N	Handicaps/Disabilities	Y N
Allergies to any Drugs	Y N	Hearing Impairment	Y N
Allergies to Latex	Y N	Heart Murmur	Y N
Rheumatic/Scarlet Fever	Y N	Hemophilia	Y N
Hepatitis	Y N	HIV +/AIDS	Y N
Cancer	Y N	Congenital Heart Disease	Y N
Kidney/Liver Condition	Y N	Convulsions/Epilepsy	Y N

If yes to any of the above, please explain: _____
Has the patient been treated for asthma? YES NO Date of last attack? _____/_____/_____
What triggered the attack? _____
Hospitalized for asthma? YES NO Asthma medication: _____
Is the patient developmentally delayed? YES NO
Please list any medical conditions the child may have not listed above: _____
Current Medications: _____
Any Allergies? _____
Under a physician's care? YES NO Condition: _____
Patient's physician: _____ Phone: ( )_____

I understand that the information I have given is correct to the best of my knowledge and it is my responsibility to inform this practice of any changes in my child's medical status.

_____ _____ _____
Signature of Parent/Guardian Print Name Relationship to Patient

_____ _____
Signature of Doctor Date