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

Is the child's water fluoridated? Y/ N Does the child take fluoride supplements? Y / N
Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD) Y N
Does the child brush his/her teeth daily? Y / N Does the child floss his/her teeth daily? Y / N
Does the child take vitamins, if yes please circle which one: gummy chewable

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

Is immunization status current? Y/ N

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
ADD/ADHD	Y / N	Autism/Aspergeus	Y / N

If yes to any of the above, please explain: _____
Patient's physician: _____ Phone: _____
Under a physician's care? YES NO Condition:_____
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? _____

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