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MEDICAL/ DENTAL HISTORY/CONTACT UPDATE (Required Every 6 Months)

CHILDS NAME _____
 DOB _____
 ADDRESS (Parent/Guardian) _____
 CITY _____ STATE _____ ZIP CODE _____
 HOME # _____ CP# _____ WORK# _____
 EMAIL _____

DO YOU HAVE ANY CONCERNS/QUESTIONS ABOUT YOUR CHILDS DENTAL HEALTH THAT WE CAN ANSWER TODAY ?

****Any Allergies?** _____

In order to keep your child's record up to date and accurate, Please CIRCLE any changes and note below to explain/clarify :

<i>Home address</i>	<i>medical condition</i>	<i>oral habits</i>
<i>phone number</i>	<i>heart murmur</i>	<i>speech therapy</i>
<i>parents marital status</i>	<i>current medicines</i>	<i>stained teeth</i>
<i>financial responsibility</i>	<i>hospitalization</i>	<i>broken teeth</i>
<i>dental insurance</i>	<i>allergies</i>	<i>crooked teeth</i>
<i>Parents name</i>	<i>behavior problems</i>	<i>mouth sores/ulcers</i>

SIGNATURE PARENT/GUARDIAN _____
RELATIONSHIP TO CHILD _____
TODAYS DATE _____

**FOR THE SAFETY OF OUR PATIENTS AND YOUR CHILD, WE REQUIRE MEDICAL HISTORY UPDATES
 THANK YOU FOR YOUR TIME**

