Date: _____

# MEDICAL HISTORY UPDATE

Patient's Name _____

Patient's Date of Birth ____ /____ /_____ ☐ Male ☐ Female

**IMPORTANT NOTICE: WE REQUIRE A PARENT OR LEGAL GUARDIAN BE PRESENT AT ALL APPOINTMENTS. PLEASE NOTIFY THE FRONT DESK IF YOU ARE NOT THE PARENT OR LEGAL GUARDIAN OF THE PATIENT.**

Has your child's medical history changed since your last visit to this office?..... YES NO
*If yes, please explain:*

Is your child currently taking any medication? ..... YES NO
*If yes, please explain:*

Has your child been in the hospital in the last year? ..... YES NO
*If yes, please explain:*

Is there anything you feel we should know about your child's health history? ..... YES NO
*If yes, please explain:*

Does your child have any food or fruit allergies? ..... YES NO
*If yes, please explain:*

What do you or your child like most about coming to our office?

Is there anything we could do to make your visits to our office better?

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff of Pediatric Dentistry of Brandon PA to perform the necessary dental services my child may need. I understand that I am responsible for the cost of these dental services at the time of the visit, unless prior arrangements have been made.

_____ _____

Signature of Parent or Legal Guardian Date