Annual Update

You may fill this form out on-screen and print if desired

YOUR CHILD:

Child's Legal Name: _____ Nickname: _____

Birthdate: _____ Age: _____ School: _____ Grade: _____

CONTACT INFO:

Cell Phone: _____ Home Phone: _____ Email: _____

Address: _____

INSURANCE INFO:

Insured's Name: _____ DOB: _____ SSN# _____

Relationship to child: _____

Employer name: _____ INS co: _____

Member ID #: _____ Group #: _____

INS Co Address: _____

HEALTH HISTORY UPDATE:

Since your child's last visit has any of the following changed:

Allergy to medications: _____

Child currently taking any medications: _____

Any Medical problems: _____

☐ Asthma: if yes please explain: _____

☐ Heart Issues: if yes please explain: _____

☐ Pre-Medication required: ☐ YES or ☐ NO If yes what medication: _____

☐ Convulsions/Epilepsy : _____ Controlled with meds: _____

☐ Behavior/Learning Problems: Autism, Aspergers Syndrome , Etc: _____

☐ Cancer: _____

☐ Diabetes: _____

Comments: _____

_____

AUTHORIZATION & RELEASE: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in your child's medical history or dental insurance. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practioners. I authorize and request my insurance company to pay directly to the denist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Parent/ Guardian: _____ Date: _____

Printed Name: _____ Relationship to child: _____

Dentistry 4 Children & Teens 2

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