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

About Your Child

Child's Name ______________________ DOB __________

Parent's Name __________ Address (Parent/Guardian) __________

City __________ State __________ Zip Code __________

Home # __________ Cell # __________ Work # __________

Email ______________________

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

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**Any Allergies? ______________________

In order to keep your child's record up to date and accurate, Please check any changes since the last six months and note below to explain/clarify :

Bad Breath
Food collection between teeth
Periodontal treatment
Sensitivity to sweets
Bleeding gums
Grinding or clenching teeth
Sensitivity to cold
Sensitivity when biting
Clicking or popping
Loose teeth or jaw
Broken fillings
Sensitivity to hot
Sores or growths in mouth

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Parent/Guardian Name __________ Relationship to Child __________

Parent/Guardian Signature __________ Date __________

For the safety of our patients and your child, we require medical history updates. Thank you for your time.

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