

Dental Care 4 Kids
Patient Information/Medical History Update

Patient Name _____ Birthdate _____
Today's Date _____ Immunizations up to date? _____
Address _____ Phone Number _____
Name of Insurance Company _____
Please list any medical conditions or non-drug allergies your child has: _____

Is your child allergic to any medications? Yes ___ No ___ Please list: _____

Have there been any changes in your child's medical history since their last visit? Yes ___ No ___ Please list: _____

Is your child taking any medications? Yes ___ No ___ Please list: _____

Does your child have heart or other medical conditions that may require antibiotic pre-medication prior to a dental appointment? Yes ___ No ___

Signature _____ Relationship to patient _____

Have there been any changes in your insurance?

Insurance information:

Insured's name _____

Relationship to patient _____

Social Security # of insured _____

Date of birth of insured _____

Employer _____

Insurance Company Name _____

Group # _____ Phone # _____

*We may request a copy of your insurance card or a claim form at the visit

We recommend that fluoride be placed on your child's teeth whenever they receive a cleaning. This serves to replenish what's polished off the enamel of the teeth. Many insurance companies limit this benefit for clients and may not cover your child's fluoride. In the event that your insurance doesn't provide this benefit, the cost is your responsibility.

Please initial below whether or not you want fluoride used for your child:

Yes, place fluoride after cleaning _____ No, don't place fluoride _____

Patient(s) Name: _____ Patient(s) DOB: _____

Completed by (name): _____ Relationship to patient _____

Preference Regarding Communications of Health Information for Patients of Dental Care 4 Kids

I wish to be contacted in the following manner(s) regarding the patient's care:

Home Telephone: _____ Work Telephone: _____

OK to leave message with detailed information OK to leave message with detailed information

Leave message with call back number only Leave message with call back number only

Cell Telephone: _____ Email address: _____

OK to leave message with detailed information OK to include detailed information

Leave message with call back number only Send contact information only

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information by persons not listed on the original family paperwork will require specific authorization prior to the disclosure of any medical information.

Signature of Parent/Legal Guardian: _____ Date: _____