LONE STAR PEDIATRIC DENTAL & Braces

Medical History Update

Parent/Guardian Name: _____ Date of Birth: _____

Relationship to Patient: _____ Email: _____

Patient Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Cell Phone: _____ Home Phone: _____ Other: _____

Insurance Company: _____ Insurance Ph#: _____

Policy Holder: _____ Policy Holder DOB: _____

Policy Holder ID#: _____ Policy Holder SS#: _____ Relationship to Patient: _____

Does the patient have any additional insurance (secondary)? Y / N **If yes, please complete the section in bold.**

Insurance Company: _____ Insurance Ph#: _____

Policy Holder: _____ Policy Holder DOB: _____

Policy Holder ID#: _____ Policy Holder SS#: _____ Relationship to Patient: _____

Have there been any changes in patient's health since last dental appointment? YES NO

Medications: _____

Allergies: _____

Has patient had any history of or difficulty with any of the following? If yes, please check:

___AIDS/HIV	___Cerebral palsy	___Eating disorder	___Kidney problems
___Asthma	___Chicken pox	___Fainting	___Liver disease
___Autism	___Covulsion/Epilepsy	___Hearing problems	___Measles
___ADHD/ADD	___Drug/Alcohol abuse	___Heart surgeries	___Pregnant
___Abnormal bleeding	___Diabetes	___Hepatitis	___Mental disorders
___Blood transfusion	___Sinus problems	___Anxiety disorder	___Problems with anesthesia

Other: _____

Patient's Physician: _____ Phone #: _____

_____ _____

Signature of parent/legal guardian (or patient if 18+) Date

Please specify relationship to patient:

____Parent with legal custody ____Guardian with legal custody ____Patient (if 18 or older)

*************FOR OFFICE USE ONLY*************

I have reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor Initials: _____ Date: _____