WELCOME UPDATE

Tell Us About Your Child Today's Date: _____/_____/_____

Name: _____ Address: _____

Birthdate: _____/_____/_____ City: _____ State: _____ Zip: _____

Phone #_____

Parents Information

Mother Stepmother Guardian Birthdate: _____/_____/_____ Phone #_____ Alternate Phone #_____

Name: _____ Address: (if different from child's) _____

Occupation: _____ Employer: _____ Email Address: _____

Father Stepfather Guardian Birthdate: _____/_____/_____ Phone #_____ Alternate Phone #_____

Name: _____ Address: (if different from child's) _____

Occupation: _____ Employer: _____ Email Address: _____

Insurance Information

Insurance Co. Name: _____ Id#: _____ Group #: _____ Phone #_____ Subscriber: _____

Sec. Insurance Co. Name: _____ Id#: _____ Group #: _____ Phone #_____ Subscriber: _____

Medical History

Please list any changes to your child's medical history: _____

Please list any serious medical problems or recent hospitalizations: _____

Please list all drugs the child is currently taking: _____

Please list all drugs that cause the child allergic reactions: _____

Please list any specific dental concerns that you have today: _____

Has the child had/experienced any of the following: PLEASE MARK AN ANSWER FOR ALL QUESTIONS BELOW:

Y/N	Y/N	Y/N	Y/N
☐☐Abnormal Bleeding	☐☐ Chicken Pox	☐☐Kidney Problems	☐☐ Speech Delay
☐☐ADHD	☐☐Congenital Heart Defect	☐☐Lice	☐☐ Tonsillitis
☐☐Aids/HIV+	☐☐Convulsions	☐☐Liver Problems	☐☐ Tuberculosis (TB)
☐☐Allergies (List Below)	☐☐Developmental Delay	☐☐Lupus	
☐☐Anemia	☐☐ Diabetes	☐☐Measles	
☐☐Asthma	☐☐ Handicaps/Disabilities	☐☐Mitral Valve Prolapse	
☐☐Autism/Related Disorder	☐☐Hearing Impairment	☐☐Mononucleosis	
☐☐Blood Disorders	☐☐Heart Murmur	☐☐Rheumatic Fever	
☐☐Blood Pressure High/Low	☐☐ Premed Required	☐☐Scarlet Fever	
☐☐Blood Transfusion	☐☐ Hemophilia	☐☐Seizure Disorder	
☐☐Cancer	☐☐ Hepatitis	☐☐Sickle Cell Anemia	
☐☐Cerebral Palsy	☐☐ Hives	☐☐Skin Rash	

Any medical history not listed above? Please explain: _____

_____

Signature of Parent or Guardian **Date**