Health History Update (revised 5/4/10)

Date _____ **Patient Name:** _____

☐ Yes ☐ No Have there been any changes to insurance, address or phone number? If so, provide _____

☐ Yes ☐ No Is your child in good health? Name of child's physician _____
Date of last physical exam _____

☐ Yes ☐ No Has your child had any recent health problems or significant injuries? _____

☐ Yes ☐ No Has your child recently been hospitalized? Please give reason and dates_____

☐ Yes ☐ No Is your child allergic to anything?_____

☐ Yes ☐ No Is your child currently taking any medications? Please give medication, dose, and reason_____

☐ Yes ☐ No Do you have fluoride in your water?

☐ Yes ☐ No Is your child up to date on all vaccinations?

Please check if your child has been treated for any of the following:

☐ Heart disease	☐ Abnormal Bleeding	☐ Transfusions & Dates_____
☐ Heart murmur	☐ Spina Bifida	☐ Sickle Cell disease
☐ Liver/GI disease	☐ Diabetes	☐ HIV/AIDS
☐ Kidney disease	☐ Rheumatic fever	☐ Hepatitis
☐ Speech/hearing	☐ Seizures	☐ Cleft lip/palate
☐ Vision problems	☐ Congenital birth defects	☐ Personality/social
☐ Cancer/tumors	☐ Recurrent headaches	☐ Frequent infections
☐ Anemia	☐ Blood disorder	☐ Autism
☐ Abuse	☐ TB	☐ Emotional problems
☐ ADD/ADHD	☐ Arthritis	☐ Adverse Drug Reaction
☐ Asthma	☐ Mental delays	☐ Physical delays
☐ Cerebral palsy	☐ Snoring	☐ Endrocrine disorder
☐ Tonsil/adenoid problems		☐ Other Issues

Please explain any items checked: _____

_____

The following treatment has been recommended at this visit. **Please indicate your approval or refusal by initialing "Yes" or "No".**

Tx recommended at this recall:

BW PA FL PANO
Notes: _____

FLUORIDE/X-RAY APPROVAL
Bitewings: Yes ___ No ___
PA/Pano: Yes ___ No ___
Fluoride: Yes ___ No ___

It is your responsibility to know your insurance benefits (if applicable). Your insurance is a contract between you and your insurance company. Our office is not responsible for knowing frequencies, coverage, and limitations.

Signature _____ Date _____

Relationship to Patient: _____ Provider initials _____