

Patient Information Update

Child's Legal Name Preferred Name Gender Preference

Child's Home Street Address City State Zip

Name of Person Completing Paperwork Relationship to Child

Who has legal custody of the child? _____

Parent/Guardian Name Parent/Guardian Name

Relationship to Child Relationship to Child

Primary Phone # Secondary Phone # Primary Phone # Secondary Phone #

Email Email

Check here if address same as child's OR indicate below Check here if address same as child's OR indicate below

Address: _____ Address: _____

Parent's/Guardians Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ Domestic Partners ___

Has the child's dental insurance changed since the last visit? Yes ___ No ___ *If YES, please inform the front desk staff*

Check any of the following which your child has had or presently has:

- | | | |
|--|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emotional Impairment | <input type="checkbox"/> Premature Birth |
| <input type="checkbox"/> Artificial Joint/Valve | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Physical Impairment |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis/Liver Disorder | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Autism | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sickle Cell Anemia/Trait |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> HIV | <input type="checkbox"/> Speech Impairment |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Vision Impairment |

Check here if NONE apply

Please explain any of the above checked conditions or any serious medical conditions not listed: _____

Please list all medications your child is currently taking: _____

Please list all medications your child has an allergic reaction to: _____

Child's Physician: _____ Physician Phone #: _____

I understand that the above information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes to my child's medical status.

Signature of Parent or Guardian

Date