PATIENT INFORMATION UPDATE

PLEASE COMPLETE THIS FORM TO KEEP OUR RECORDS CURRENT

CHILD'S NAME | NICKNAME | AGE | DATE OF BIRTH

CHILD'S PHYSICIAN | CITY | DATE LAST SAW PHYSICIAN

HAS YOUR CHILD HAD HISTORY OF? (CHECK IF YES) – PLEASE DESCRIBE BELOW

___HEART TROUBLE OR MURMURS
___ DIABETES
___ RHEUMATIC FEVER
___ ALLERGIES (PLEASE LIST BELOW)
___ DRUG SENSITIVITIES
___ KIDNEY/LIVER INVOLVEMENT
___ BLEEDING PROBLEMS
___ SEIZURES/CONVULSIONS
___ ASTHMA
___ BRAIN INJURY
___ HEPATITIS
___ EPILEPSY
___ HIV POSITIVE/AIDS
___ BLOOD DISORDERS
___ NONE

IS THERE ANYTHING REGARDING YOUR CHILD'S PHYSICAL, MENTAL OR EMOTIONAL HEALTH THAT WE SHOULD KNOW?

Current Medications:

Allergies – please describe:

FATHER			**MOTHER**		
Full name			Full name		
SSN			SSN		
Birth date			Birth date		
Residential address (street)			Residential address (street)		
City	Zip	Phone	City	Zip	Phone
Cell	E-mail		Cell	E-mail	
Employed by			Employed by		
Business address (street)			Business address (street)		
City	Zip	Phone	City	Zip	Phone
Name of dental insurance co.			Name of dental insurance co.		
Group no.			Group no.		

PATIENT'S PRIMARY RESIDENCE? (PLEASE CHECK) MOTHER ☐ FATHER ☐ BOTH ☐

PLEASE NOTE: If the family is not living together, the parent bringing the child is responsible for the child's account. Payment is expected at the time services are rendered.

SIGNATURE_____ RELATIONSHIP TO CHILD_____ DATE_____

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451 W. GONZALES ROAD #300
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REV. 03/28/2012

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