dental partners of Vero Beach

Comprehensive Dentistry
Airway Orthodontics
& Sleep Solutions
For Patients of All Ages

Child Information and Health History Update

We appreciate you taking the time to update your records so we can treat all of your dental needs to the best of our ability. Thank you

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

DOB _____ Parent: _____

E Mail Address: _____

Phone: Home _____ Mobile _____ Work _____

Address: _____

City _____ State_____ Zip_____

We communicate with our patients through phone, e-mail and texts. Which method would you prefer?

Check all that apply: ❑ House Phone ❑ Mobile Phone ❑ E mail ❑ Text Message

Medical History Update

Does the patient have any CURRENT HEALTH PROBLEMS? _____

What Medications, Vitamins, Herbs, Supplements is the patient currently taking?_____

_____

Primary Care
Doctors Name: _____ Phone: _____

Please indicate if the patient has any allergies or sensitivities to any of the following.

(Please check all that apply)

❑ Aspirin	❑ Sulfa	❑ Food Allergies	❑ Latex
❑ Metals	❑ Erythromycin	❑ Penicillin	❑ Novocain
❑ Codeine	❑ Nitrous Oxide	❑ Other _____	

Medical History

Are there any medical conditions that we need to be aware of? Please check all that apply.

❑ Diabetes, list medication _____ ❑ Anxiety/Nervous Problems ❑ Asthma
❑ Insulin Dependent ❑ Non-Insulin Diabetic
❑ Other _____

❑ Recent Medical Concerns or Surgeries _____

_____

I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly for my child. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Signature _____ Date _____