



For PC and Mac



For phone and tablet



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Today's Date: \_\_\_\_\_

### Health History Update Form

Child's Name: \_\_\_\_\_

Guardian's Name: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

Guardian's Phone Number: \_\_\_\_\_ Guardian's Email Address: \_\_\_\_\_

Has your insurance changed in the last 6months? Yes No

#### Health History

- |                            |                            |                         |
|----------------------------|----------------------------|-------------------------|
| Abnormal Bleeding          | Handicaps/Disabilities     | Allergies to any Drugs  |
| Hearing Impairment         | Any Hospital Stays         | Heart Disease/Murmur    |
| Any operations             | Hepatitis                  | Asthma                  |
| HIV+/AIDS                  | Cancer                     | Kidney/Liver Conditions |
| Congenital Birth Defects   | Rheumatic/Scarlet Fever    | Convulsions/Epilepsy    |
| Allergies to Latex Product | Pregnancy                  | Diabetes                |
| Tuberculosis               | Hemophilia/Blood Disorders | ADD/ADHD                |
| Reflux/GI Problems         | Autism                     |                         |

Please discuss any serious medical conditions the child has currently or has had in the past (including reason for any hospital stays or surgeries):

Please list all medications the child is currently taking:

Please list all medications and food the child is allergic to:


Child's Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_

Is child currently under the care of a physician? Yes No

Please describe the child's current physical health: GOOD FAIR POOR

Our office is committed to meeting or exceeding the standards of infection control mandates by OSHA, the CDC and the ADA. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Relationship of the patient: \_\_\_\_\_

III. Signature of Parent/Guardian Click  icon on the toolbar to add the digital signature. \_\_\_\_\_