BUCKEYE PEDIATRIC DENTISTRY

Patient Update Form

Patient Name: _____ **Today's Date:** _____ **Phone #:** _____

Current Address: _____ **Email:** _____

Current Dental Insurance Co: _____ **Member ID:** _____

Why did you bring your child to the dentist today?

_____

_____

Has your child ever had a serious/difficult problem associated with previous dental work? **Y N**

Is your child's water fluoridated? **Y N**

Is your child taking fluoride supplements? **Y N**

Has your child ever had pain/tenderness in their jaw joint (TMJ/TMD)? **Y N**

Does your child brush their teeth daily? **Y N**

Does your child floss their teeth daily? **Y N**

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Pharmacy #: _____

Your child's current physical health is:

☐ Good ☐ Fair ☐ Poor

Please list all medications, supplements and/or natural remedies that your child is currently taking:

_____

_____

Please list any allergies your child has (drugs, foods, environmental, etc.): _____

_____

Has your child ever experienced/been diagnosed with any problems/conditions in the following areas?

Y N Thyroid/Endocrine/Diabetes Or Other Metabolic Conditions
Y N Heart/Cardiovascular
Y N Liver or Kidneys
Y N Cancer/History of Cancer
Y N Seizures/Neurological Disorders
Y N Hemophilia/Blood Disorder
Y N Autism Spectrum Disorder
Y N Asthma/Respiratory
Y N GERD/GI Disorders
Y N Tuberculosis
Y N Skin Conditions
Y N Prematurity
Y N Hearing Impairment
Y N ADHD

Does your child have any of the following (please circle and elaborate)? Anxiety, Sensory Issues or Behavioral, Emotional, Communication or Developmental Disorders

_____

_____

Does your child have any of the following habits (please circle and elaborate)? Lip Sucking/Biting, Nail Biting, Nursing or Bottle Habits, Thumb/Finger Sucking _____

_____

Has your child ever had surgery or been hospitalized? **Y N**
Please explain: _____

_____

Please share anything else about your child that you feel we should know: _____

_____

_____

The information that I have given is correct to the best of my knowledge and I understand that it is my responsibility to inform the office of any changes in my child's medical status. I authorize the dental staff to perform the dental services that my child may need.

_____ _____

Printed Name Parent/Guardian Signature Date

OFFICE USE ONLY – TO BE COMPLETED BY TREATING DENTIST/AUTHORIZED STAFF MEMBER

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Initials: _____ Date: _____ Comments: _____

Our Office Is Committed to Meeting or Exceeding the Standards of Infection Control Mandated by OSHA, the CDC & the ADA. Please Ask Us for More Details on Our Policies and Procedures.