****Patient Update Form****

Child's Name: ____________________________________ **DOB**_______________ **Weight** _____________

Child's Name: ____________________________________ **DOB**_______________ **Weight** _____________

Child's Name: ____________________________________ **DOB**_______________ **Weight** _____________

Child's Address: ____
Child Lives with: ____

****Each patient will receive fluoride treatment at every routine cleaning appointment unless you specify otherwise****
Please Initial ______________

Has your insurance changed within the last 6 months? YES NO
If Yes:
Current Insurance Carrier __________________________________ Individual Policy: Y N
Subscriber Name______________________________ DOB ______________________
Subscriber ID#: ___________________________ Subscriber SS#: _______________________
Employer: __________________________________ Group #: ___________________________
Insurance Claim Address: ____
Insurance Phone #: ____________________________ Relationship to Patient ______________________

Parent/Legal Guardian ____
DOB ________________ SS#: ________________________
Address ____
(H#)____________________ (W#)__________________(C#)________________
E-Mail _____________________________ Relationship to Patient ________________________
Employer ___________________________________

Parent/Legal Guardian ____
DOB ________________ SS#: ________________________
Address ____
(H#)____________________ (W#)__________________(C#)________________
E-Mail _______________________________ Relationship to Patient _________________________
Employer ___________________________________

Emergency Contact (other than listed above):_________________________
Emergency Contact Phone#:______________________ Relationship to Patient ______________________

Has the patient's Medical History changed since his/her last visit? YES NO
If yes, how?____

Is the patient currently taking any OTC and/or Prescription medications? YES NO
If yes, please list medication name and dosage: ______________________________
____

Has Patient been experiencing any dental problems recently? YES NO
If yes, please explain: ____
____

Signature of Parent/Legal Guardian:_________________________________ **Date** ____________