



Demographic and Medical Update

Patient Name: _____ DOB: _____

Address: _____

BEST Phone Number: _____ (mobile) _____ (home)

BEST Email: _____

- Has your child seen his/her physician or had any hospitalizations since their last visit? **Yes** ____ **No** ____

If Yes, explain: _____

- Have there been **ANY** changes in your child's medical history since their last visit? **Yes** ____ **No** ____

If Yes, explain: _____

- Does your child have any allergies? **Yes** ____ **No** ____

If Yes, explain: _____

- Please list **ALL** current medications and reason for taking them:

- Is your child experiencing any dental problems? **Yes** ____ **No** ____

If Yes, explain: _____

Name of Person completing this form: _____

Relationship to child: _____ Date: _____

*****PLEASE GIVE US YOUR UPDATED INSURANCE CARD*****