Five Cities Pediatric Dental Group & Orthodontics

Thank-you for continuing to be a part of our office family! Please take a moment to complete this annual update form. Our practice philosophy is based on preventive care, for a lifetime of healthy smiles.

Date: _____

Child's name: _____ Male Female Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Person Responsible for the Account:

Name: _____ Relation: _____

Address: _____ City: _____ State: _____ Zip: _____

Status (circle one): single married divorced separated

Phone #: _____ E-mail: _____

Is there a change in the information in this section? (circle one) YES NO
If no, proceed to next section If YES, please update below:

Tell us about you:

Father's name: _____ **Mother's Name**: _____

Employer: _____ Employer: _____

Preferred Contact #: _____ Preferred Contact #: _____

Alt tel #: _____ ext: _____ Alt tel #: _____ ext: _____

Status (circle one): single married divorced separated Status (circle one): single married divorced separated

Guardian Email: _____

Emergency Contact (**non-guardian**): _____ Relation: _____

I attest that my responses on the front and back of this form are true and correct and that I have not omitted any pertinent information.

Guardian's signature: _____

Print name: _____ Date: _____

MEDICAL UPDATE:

Patient name: _____ Date: _____

State the general condition of the child's health. Please give details: _____

NAME of pediatrician or physician(s):_____

Has your child ever had any surgeries? (circle one) Yes No

If yes, for what condition and when: _____

Are your child's vaccinations up to date? Yes No

Please list any medications: _____

Does your child have any of the following conditions or problems? (please circle yes or no):

Asthma	Yes	No	Heart condition	Yes	No
Inhaler ever prescribed	Yes	No	Heart murmur	Yes	No
Bleeding disorder	Yes	No	Heart surgery	Yes	No
Attention Deficit Disorder (ADD)	Yes	No	Rheumatic fever	Yes	No
Attention Deficit Hyperactivity Disorder (ADHD)	Yes	No	Brain injury	Yes	No
Sight or hearing limitations	Yes	No	Fainting/Seizures	Yes	No
Immune disorder (including HIV or AIDS)	Yes	No	Epilepsy/Convulsions	Yes	No
Cancer, tumors or growths	Yes	No	Diabetes	Yes	No
Gastric reflux (GERD)	Yes	No	Hepatitis/Jaundice	Yes	No
Autistic spectrum disorder	Yes	No	Kidney Disease	Yes	No
			OTHER: _____		

Is your child allergic to or has he/she had a reaction to any of the following?

Local anesthetic (Novocain)	Yes No	If yes, what:	_____
Penicillin, Amoxicillin or other antibiotic	Yes No	If yes, what:	_____
Aspirin or other pain medicine	Yes No	If yes, what:	_____
Latex rubber	Yes No	If yes, what:	_____
Metals (nickel, tin, silver)	Yes No	If yes, what:	_____
Any other food, drug or medication	Yes No	If yes, what:	_____
Any family history of severe allergies	Yes No	If yes, what:	_____

DENTAL UPDATE:

Has your child experienced an unfavorable medical or dental visit? (circle one) Yes No

If yes, explain why_____

Does your child have any of the following habits: Bottle, cup, or breastfeeding at night? Past Present N/A

Thumb or finger sucking / pacifier use? Past Present N/A

Others? _____

What is your greatest dental concern for your child? _____

For how long have you had this concern? _____

How many times per day does your child brush his or her teeth? (circle one) 0 1 2 2 or more

My child uses dental floss: Daily Weekly Seldom Never

For children 8 years and under, does an adult assist with brushing? Yes No N/A

Does your child take fluoride supplements? Yes No

Does your child use fluoride toothpaste? Yes No Fluoride mouth rinse? Yes No

Date of the last dental exam (if not at this office): _____ Dentist's name:_____