ALL SMILES
ORTHODONTICS & CHILDREN'S DENTISTRY

MEDICAL HISTORY UPDATE FORM

CHILD'S NAME:			
CHILD'S BIRTH DATE:			
	YES	**NO**	**IF YES, PLEASE UPDATE**
CHANGE IN ADDRESS			
CHANGE IN INSURANCE			Name of insurance _____ Primary subscriber name _____ Social security number _____ Subscriber birth date _____
Have there been any changes in your child's health since his/her last dental visit?			
Has your child been ill, hospitalized, or had surgery since the last dental visit?			
Is your child taking any pills or medications right now?			What for?_____ Name and dose of medication_____
Does your child have any new allergies or reactions to drugs or medications?			
Has your child seen an orthodontist?			Dr._____
Who is your child's medical doctor?			Dr._____

PARENT SIGNATURE_____ **DOCTOR SIGNATURE**_____

DATE_____ **DATE**_____