MEDICAL UPDATE

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Today's Date_____
Child's Name (Last)_____(First)_____(M.I.)_____
Sex_____ Age_____ Date of Birth_____
E-MAIL (to confirm appointments)_____

*Starred items fill out only once per family

*Home address

_____
_____

*Home Phone #(___)_____Mom Cell(___)_____ Dad Cell (___)_____

*Has your insurance changed? Yes_____ No_____
If yes please give your card to the front desk

Please fill in for each child: Medical Health Information

Name of Medical Physician:_____Phone #_____

Is the child taking any medication, **including birth control?** (Due to medication interactions)
( ) Yes ( ) No Please explain _____

Has the child ever been Hospitalized? ( )Yes ( ) No Please explain _____

Please List any behavioral, developmental or emotional disorders, hearing loss or other conditions._____
_____

Has the child ever had any of the following? Please check those that apply:

☐ AIDS or HIV positive	☐ Blood/bleeding disorder	☐ Eye Disease	☐ Mental/Nervous disorder
☐ Allergies: Penicillin	☐ Cancer	☐ Glandular/Hormonal disease	☐ Radiation/Chemotherapy
☐ Allergies/Seasonal	☐ Cleft lip or palate	☐ Heart Disease/Surgery	☐ Stomach Problems/Ulcers
Other Drug Allergies_____			
☐ Anemia	☐ Diabetes	☐ Heart Murmur/Rheum Fever	☐ Tuberculosis
☐ Asthma/Respiratory Dis	☐ Ear Disease	☐ Hepatitis(liver disease)	☐ Tumors/Growths
☐ Arthritis/Joint Disease	☐ Eplipsy/Seizures	☐ Kidney Disease	☐ Other

Is your child seeing an Orthodontist now YES____ NO____
Which one? _____

Is there anything you wish to discuss with the Doctor?_____
_____

_____Date_____Relationship to child_____
Signature of Parent, guardian, or patient (if of legal age)

Jan-11