Small To Tall Dentistry For Children, PLLC

Please Update Your Information

Date _____

Child's Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone Number _____

Mother/Father/Guardian _____

Address _____ City _____State _____ Zip _____
(if different than child)
Cell Number _____ E-mail _____

Father/Mother/Guardian _____

Address _____ City _____ State _____ Zip _____
(if different than child)
Cell Number _____ E-mail _____

Parent's Marital Status (circle one) Single Married Divorced Separated Partnered Widowed

MEDICAL INFORMATION

Physicians Name _____

Pharmacy Name & Location _____

Circle One

Since your child's last visit have there been any changes to his/her health? If yes, explain: yes no

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Is there anything about your child's teeth, mouth or jaw that concerns you? If yes, explain: yes no

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Is your child presently under the care of a physician for any medical reason? If yes, what: yes no

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If the doctor recommends taking x-rays do you give permission for them to be taken today? yes no

Is the child currently taking any medications? If yes, what: _____ yes no

Does your child have a medical condition (heart murmur, heart defect, etc.) that requires antibiotics before treatment? If yes, what: _____ yes no

Is your child allergic to any medications, latex or any other product? If yes, what: yes no

_____

I understand the above information to be correct to the best of my knowledge and it is my responsibility to inform this office of any future changes to the information I have provided.

Signature _____ Date _____ Reviewed by: _____