CHILDREN'S DENTISTRY OF LITHONIA

Update Form

YOUR CHILD'S INFORMATION __ Male __ Female

Name: _____ Date of Birth: _____

Cellular Telephone Number: _____ E-mail Address: _____

Home Telephone Number: _____ Work Telephone Number: _____

Address: _____ City:_____State:____ZIP: _____

Pediatrician Name: _____Pediatrician Phone # _____

Pediatrician Address: _____City:_____State:____ ZIP:_____

GENERAL INFORMATION

Who is accompanying the child today? _____

What is your date of birth? _____What is your relation to this child?_____

INSURANCE INFORMATION

Name of Insured: _____

Insurance Company Name: _____

Insurance Company Address: _____

City:_____State:____ZIP: _____ Group # _____

Union/Local/Policy # _____Deductible: _____ Max annual benefit:_____

DENTAL/MEDICAL HISTORY

List **ANY** medications (prescription/non-prescription) that your child currently takes:

_____

Does your child have any allergies to medications or materials including latex?

_____

Please describe any surgeries or hospitalizations that your child has had:

_____

Please elaborate on any concerns that you have about your child's mouth:

_____

PLEASE CIRCLE "Y" FOR YES OR "N" FOR NO AS IT RELATES TO YOUR CHILD'S HEALTH

Y/N	Heart Murmur/Heart Problem
Y/N	Shunts
Y/N	Cancer
Y/N	Diabetes
Y/N	Rheumatic Fever
Y/N	Liver Problems/Hepatitis
Y/N	Kidney Disease
Y/N	HIV Positive
Y/N	Hemophilia/Bleeding problems/Anemia
Y/N	Hearing Impairment
Y/N	Speech Issues
Y/N	ADD/ADHD/Hyperactive
Y/N	Frequent Headaches
Y/N	Asthma
	Last Attack _____
Y/N	Convulsions/Epilepsy/Seizures
Y/N	Pregnant
Y/N	Physical/Mental Impairment
Y/N	Learning Disability/ Developmental Delay
Y/N	Personality/Social Disorder
Y/N	Autism
Y/N	Dermatologic or Skin Conditions

Does your child require antibiotics prior to dental visits? Y/N

Does your child have any prosthetics? (Example: artificial limbs, prosthetic eye, pins, screws, etc.) Y/N

Any other medical problems related to this child: Y/N
If yes, please lists:_____

The information I have given is correct to the best of my knowledge and I understand that it will be held in the strictest of confidence. I also understand that it is my responsibility to inform this office of any changes in my child's medical status, address, phone number, e-mail address or any other personal information. I give Children's Dentistry of Lithonia, LLC permission to perform cleanings, x-rays, exams, and fluoride treatments, sealants (with prior authorization), or emergency treatment for my child.

Signature of parent/guardian:_____Date:_____