

FAMILY INFORMATION UPDATE

Family Name: _____ Date: ____/____/____
 Address Change (if any) _____ City _____ State ____ Zip _____
 Home Phone # _____ Primary Work # to Call _____
 Mom Cell # _____ Dad Cell # _____
 E-mail Address (for patient correspondence only)
 Name _____ E-mail _____
 In the event that the above e-mail address would fail, please provide another valid e-mail address:
 Name _____ E-mail _____

PDSH WILL USE THE PROVIDED INFORMATION FOR PATIENT CORRESPONDENCE ONLY. THIS INFORMATION WILL NOT BE RELEASED TO ANY OTHER PARTIES OUTSIDE OF PDSH.



NEW Insurance CHANGE in Insurance NO Insurance



Since your child/children's last visit:	Child #1	Child #2	Child #3	Child #4
Names: _____	_____	_____	_____	_____
1. Do you have any dental concerns at this time? Explain: _____	Y / N	Y / N	Y / N	Y / N
2. Taken any prescription medication from a Dr? Explain: _____	Y / N	Y / N	Y / N	Y / N
3. Any ALLERGIES? (medication, latex, red dye, etc.) Explain: _____	Y / N	Y / N	Y / N	Y / N
4. Been hospitalized for any reason? Explain: _____	Y / N	Y / N	Y / N	Y / N
5. Been told that they have a heart defect/murmur? If yes, does it require premedication? Explain: _____	Y / N	Y / N	Y / N	Y / N
6. Been under the care of a physician for any other medical problem? Explain: _____	Y / N	Y / N	Y / N	Y / N
7. Been seen by an Orthodontist? Name of Orthodontist: _____	Y / N	Y / N	Y / N	Y / N



I hereby understand it is my responsibility to inform the dentist and staff of any and all health changes related to my child and that all information stated above is accurate. In the event that I would fail to pay my bill, I also agree to pay any additional charges related to the cost of collection (including but not limited to: collection agency fees, reasonable attorney fees and court costs).

Parent/Legal Guardian Signature _____ Date _____