PERIODIC EXAM UPDATE

Child's Name____Date___________________________________

Mailing Address____City/State/Zip___________________________

Home Phone #______________________Mother's Work #_____________________Father's Work #__________________

Mother's Cell Phone________________________________Father's Cell Phone__________________________________

Best Confirmation # __________________________________E-mail____

Please Circle One

1. Is there a change in the mother's or father's place of employment? If so, please list changes below: Yes No

   ____

2. Date of child's last physical exam by doctor.____

3. Does your child have any allergies to medications? If so, please list: Yes No

   ____

4. Is your child taking any medications at this time? If so, please list: Yes No

   ____

5. Has your child had a blood transfusion since the last visit? If so, when? Yes No

   ____

6. Does your child have a heart murmur or heart condition? Yes No

   ____

7. Has your child been diagnosed with HIV, Hepatitis or Tuberculosis since the last visit? Yes No

8. Is any special medical treatment contemplated at this time? Yes No

   ____

9. Has your child had any accidents involving the teeth or face since their last visit? If so, please describe: Yes No

   ____

10. Does your child presently have any thumb, finger or pacifier sucking habits? If so, please circle applicable habits and make comments:____ Yes No

11. Does your child have frequent headaches or muscle pain in the jaw area? Yes No

12. Is your child taking systemic fluoride supplements (tablets, drops or fluoride in vitamins)? Yes No

13. Are you on well water? Yes No

14. Is there any difficulty in brushing?_____ Flossing?_____ Yes No

15. Has your dental insurance changed since the last visit? Is so, please see the receptionist for a new insurance information form. Yes No

16. **Do you have any suggestions or comments regarding previous dental treatment or office administration? Yes No**

    ____

SIGNATURE: **X**____

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