



## Six Month Medical Update

Child's First Name \_\_\_\_\_ Last name \_\_\_\_\_  
age \_\_\_\_\_

Any Changes in your address or Phone Number?  
 yes or  no

\_\_\_\_\_  
\_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_

Any Changes in your insurance?  yes or  no  
If yes, please give your new information to front office staff.

Are there any Changes with your child's medical history since your last visit?   
 yes or  no  
If yes, Please explain \_\_\_\_\_  
\_\_\_\_\_

Is your child currently taking any medications?  
 yes or  no  
If yes, Please list: \_\_\_\_\_  
\_\_\_\_\_

Has your child been hospitalized in the last 6 months?  
 yes or  no  
If yes, Please explain: \_\_\_\_\_  
\_\_\_\_\_

Are there any concerns that we should be aware of?  
\_\_\_\_\_

Where is your water source from? \_\_\_SAWS\_\_\_AH\_\_\_Other

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental service my child may need.

Parent or Guardian's signature \_\_\_\_\_  
Date \_\_\_\_\_