

# Children's Health History Update

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Relationship: \_\_\_\_\_

Does child have or has child ever had:

YES

NO

Anemia

\_\_\_\_\_

\_\_\_\_\_

Diabetes

\_\_\_\_\_

\_\_\_\_\_

Hepatitis

\_\_\_\_\_

\_\_\_\_\_

Reaction to Local anesthetic

\_\_\_\_\_

\_\_\_\_\_

Allergies – please list medication allergies

\_\_\_\_\_

\_\_\_\_\_

Abnormal heart condition

\_\_\_\_\_

\_\_\_\_\_

Abnormal bleeding from a cut

\_\_\_\_\_

\_\_\_\_\_

Rheumatic fever

\_\_\_\_\_

\_\_\_\_\_

Heart murmur

\_\_\_\_\_

\_\_\_\_\_

Is your child under the care of a Physician now? If yes, describe below:

\_\_\_\_\_

Is any medication being taken now?

\_\_\_\_\_

\_\_\_\_\_

If so, what?

\_\_\_\_\_

Other physical conditions

\_\_\_\_\_

Name of Physician

\_\_\_\_\_

Phone number

\_\_\_\_\_

Information given by (signature)

\_\_\_\_\_

Name and Address of Dental Insurance Company:

Policy Holder Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Primary \_\_\_\_\_

Secondary \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Policy # \_\_\_\_\_

Policy # \_\_\_\_\_

ID# \_\_\_\_\_

ID# \_\_\_\_\_