Medical History Update

Basking Ridge Pediatric Dentistry

Date (DD/MM/YYYY) _____

Child's Name _____ DOB _____

Address _____

Phone (Cell) _____ (xxx)xxx-xxxx

Phone (Home) _____

Email Address _____

Pediatrician _____

Have there been any changes in your child's health? No
If yes, please explain:

_____

Does your child take Fluoride supplements? No

If yes, what is the dosage? 0.25 mg

	Yes	No
Does your child take any medications? Please list any medications your child is taking:	☐	☐
Does your child have any drug allergies? If yes, please explain _____	☐	☐
Has your child ever had heart murmur, heart valve problems or heart surgery? If yes, please explain: _____	☐	☐
Has your child had any history of diabetes, bleeding, kidney or liver disease? If yes, please explain: _____	☐	☐
Do you have any dental concerns about your child?	☐	☐

_____

Signature _____

Relationship _____

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