Pediatric Dentistry of Weston

Annual Medical/Dental Update

Patient Name_____ Age_____ Birth date_____

Home Address _____
Street City Zip

Primary Tel # _____ Secondary Tel # _____

Email Address_____ (can we send you reminders by email/text) **Yes** **No**

Has there been any change in your child's medical history since his/her last visit to our office? **Yes** **No**

(If Yes please explain) _____

Reason for today's visit (please circle one) Six month checkup Emergency visit Other_____

Is your child taking Medications? **Yes** **No** (If Yes please list) _____

Are there changes in medication since last visit? **Yes** **No** (If Yes please list)_____

Is your child currently under the care of a physician? **Yes** **No** (If Yes please list) _____

Does your child have any drug allergies? **Yes** **No** (If Yes please list) _____

If there have been changes to your dental insurance please provide us with the information below:

Insurance Company Name: _____ Telephone Number: _____
Policy Holder Name: _____ Birth date: _____
Member ID Number: _____ Group Number_____

Authorization and Release

If this patient is a minor, it becomes necessary that signed permission be obtained from the parent or guardian. Authorization is herby granted. I understand that providing incorrect information can be dangerous and it is my responsibility to inform the office of any changes in my child's health. I also authorize the staff to perform the necessary services that my child needs only after a consultation and/or explanation. Furthermore, I will be responsible for any bill incurred on this patient for dental treatment or, if I indicated someone else is responsible, permission is granted for verification.

_____ _____ _____
Parent/Legal Guardian Signature Relationship to Patient Date

(BOTTOM PORTION IS ONLY FOR OFFICE USE)

Medical concerns:

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_____ _____ _____

Samira Alempour, D.M.D. **Marcela Solarte, D.M.D** **Sabrina Roberti, D.M.D.**