Medical History Update Form

PATIENT INFORMATION

Patient _____ Date _____

Nickname _____ DOB _____ Age _____ Sex ☐ F ☐ M

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

HEALTH HISTORY

Name of child's physician _____ Phone Number _____

Location of child's physician _____ Date of last physical exam _____

☐ Yes ☐ No Are your child's immunizations up to date? _____

☐ Yes ☐ No Has your child ever had a health problem? _____

☐ Yes ☐ No Is your child currently taking any medications? Name _____

Doses and reason _____

☐ Yes ☐ No Is your child allergic to anything? _____

☐ Yes ☐ No Has your child ever been hospitalized? Please give reason and dates _____

☐ Yes ☐ No Has your child had any operations? _____

☐ Yes ☐ No Has your child had general anesthesia? Any complications? _____

Please check if your child has been treated for any of the following:

☐ Heart disease	☐ Bleeding/transfusions/Anemia	☐ Cleft lip/palate	☐ Hearing
☐ Liver disease/ Hepatitis	☐ Asthma	☐ Congenital birth defects	☐ Spectrum/Autism
☐ Kidney disease	☐ Rheumatic fever	☐ HIV/AIDS	☐ Mental delays
☐ Gastrointestinal disease	☐ Seizures	☐ Frequent infections	☐ Anxiety Problems
☐ Cerebral palsy	☐ Diabetes	☐ Physical delays	☐ ADHD
☐ Cancer/tumors	☐ Recurrent headaches	☐ Blood disorder	☐ Sensory issues
☐ Speech	☐ Reflux	☐ Allergies	☐ Other _____

Comments: _____

CONSENT FOR DENTAL TREATMENT

You have a right to accept or reject dental treatment. Prior to consenting you should consider the benefits and risks of the procedure, alternative treatments or the option of no treatment. Do not consent unless all of your questions have been answered and you have acknowledged your willingness to accept known risks and complications no matter how slight the risks. Small risks may include swallowing or inhaling of saliva or dental materials, discomfort, bleeding, post numbing bite trauma, bruising, swelling, or numbness. I understand that drugs and medications including antibiotics, analgesics and other medicines can cause allergic reactions causing redness, swelling of tissues, pain, vomiting or anaphylactic shock (severe allergic reaction). The dentists at Children's Dentistry of Northborough do everything possible to minimize or completely prevent these risks and side effects. By signing this consent you are allowing any of these dentists to diagnose and treat your child.

I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. The staff at Children's Dentistry of Northborough will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

I consent for my child to receive cleanings, dentist examinations, fluoride treatment, photographs, and x-rays. Should I agree to a treatment plan, I consent to allow the providers of this office to do sealants, fillings and other common procedures within the standards of care for the duration of my time as a patient at Children's Dentistry of Northborough. If I wish not to consent to any of the above I agree to inform the dentist the day of my appointment.

Signature _____ **Date** _____