

PERIODIC EXAM UPDATE

Child's Name _____ Date _____

Mailing Address _____ City/State/Zip _____

Home Phone # _____ Mother's Work # _____ Father's Work # _____

Mother's Cell Phone _____ Father's Cell Phone _____

Best Confirmation # _____ E-mail _____

Please Circle One

1. Is there a change in the mother's or father's place of employment? If so, please list changes below: Yes No

2. Date of child's last physical exam by doctor: _____
3. Does your child have any allergies to medications? If so, please list: Yes No

4. Is your child taking any medications at this time? If so, please list: Yes No

5. Has your child had a blood transfusion since the last visit? If so, when? Yes No

6. Does your child have a heart murmur or heart condition? Yes No

7. Has your child been diagnosed with HIV, Hepatitis or Tuberculosis since the last visit? Yes No
8. Is any special medical treatment contemplated at this time? Yes No

9. Has your child had any accidents involving the teeth or face since their last visit? If so, please describe: Yes No

10. Does your child presently have any thumb, finger or pacifier sucking habits? If so, please circle applicable habits and make comments: Yes No

11. Does your child have frequent headaches or muscle pain in the jaw area? Yes No
12. Is your child taking systemic fluoride supplements (tablets, drops or fluoride in vitamins)? Yes No
13. Are you on well water? Yes No
14. Is there any difficulty in brushing? _____ Flossing? _____ Yes No
15. Has your dental insurance changed since the last visit? Is so, please see the receptionist for a new insurance information form. Yes No
16. Do you have any suggestions or comments regarding previous dental treatment or office administration? Yes No

SIGNATURE: **X** _____