

KEYSTONE PEDIATRIC DENTISTRY  
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NOTICE TO PARENT AND/OR GUARDIAN

As part of our continued efforts to better serve you, we now require this brief update to be completed in full every six months. We greatly appreciate your understanding and cooperation!

MEDICAL HISTORY UPDATE

CHILD'S NAME \_\_\_\_\_

Today's Date \_\_\_\_\_ Date of last Medical Exam \_\_\_\_\_

Has there been any change in patient's health since last dental appointment? \_\_\_\_\_  
If yes, please describe \_\_\_\_\_

Is patient taking any new medications? \_\_\_\_\_ if so, please list \_\_\_\_\_  
\_\_\_\_\_

Has there been any injury to the teeth, head or neck since patient's last visit? \_\_\_\_\_  
If so, what \_\_\_\_\_

Do we have your permission to provide a fluoride treatment for your child today?

Circle answer please      YES                      NO

Do we have your permission to take x-rays today if the Doctor feels the need?    YES

NO

**Although we do attempt to verify your insurance coverage, we are unable to guarantee payment of fluoride treatments or radiographs. It is your responsibility to know your insurance plan**

PARENT/GUARDIAN INFORMATION

Name of responsible party accompanying patient today \_\_\_\_\_

Parent/Guardian's address \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell \_\_\_\_\_

New information requested \*\*

Email address to which we have your permission to send you reminders and messages  
\_\_\_\_\_

Dental Insurance Carrier \_\_\_\_\_

Employer carrying Insurance \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_