KEYSTONE PEDIATRIC DENTISTRY

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NOTICE TO PARENT AND/OR GUARDIAN

As a 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: _____ Date of Birth: _____

Today's Date: _____ Date of Last Pediatricians' Exam: _____

Has there been any changes in patients 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 your last visit? _____

If "Yes," please describe: _____

Is there any condition or problem you wish to bring to the dentist's attention? _____

If "Yes," please describe: _____

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

Do we have permission to take X-rays today, if the doctor feels the need? _____

Please know your insurance plan. We cannot guarantee payment by your insurance carrier

PARENT/GUARDIAN INFORMATION

Name of responsible party accompanying child today: _____

Parent/Guardian's Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PLEASE UPDATE THE FOLLOWING INFORMATION:

Current E-mail address (To which we have permission to send you reminders and messages): _____

Current Dental Insurance Carrier: _____

Employer Carrying insurance: _____

Responsible party's signature: _____ Date: _____