

Patient Update Form
It's great to see you again!!

Child's Name: _____ DOB: _____

FAMILY RECORD UPDATE

Has there been any change in your address or phone number? Yes No

If yes- New Address: _____
New Phone #: _____

Have you or your spouse changed employment? Yes No

If yes, Who? _____ New Employer: _____

Has your dental insurance carrier changed? Yes No

If yes- New insurance carrier: _____
New Policy number: _____

MEDICAL UPDATE

Does your child have a **medical condition** Dr. McCabe should be aware of? Yes No

List: _____

Is your child **allergic** to anything (including meds, foods, latex, anesthetics)? Yes No

List: _____

Have there been any changes in your child's health or medical history since Yes No
their last dental visit? Explain: _____

Is your child taking any **medications** (prescription or over-the-counter)? Yes No

List: _____

Have there been any **injuries** to the teeth, head, or neck since the last Yes No
dental visit? Explain: _____

Reason for today's visit or areas of concern you would like Dr. McCabe to
address: _____

I acknowledge that this information is correct, and I understand withholding medical/dental information can be harmful to my child during treatment.

Signature of parent/guardian

Relationship to Child

Date