West Metro Pediatric Dentistry Health Update Form

This health update must be completed by a legal guardian.

Family Information: **Family Information section only needs to be completed on one health update form per family**

Parent/Guardian at today's visit: ____ Relationship: ______________________

1. Current contact information:

   Mom Cell: ____ Dad Cell: ____

   Primary Email: ____

2. Has your mailing address changed since your last visit? Y / N

   New Address: ____City: _____________________Zip: __________

3. Has your dental insurance changed since your last visit? Y / N

   New Insurance Company/ID #/Group #: ____

Patient Information:

Child's Name: ____ Nickname: _____________________DOB:_____/______/______

1. We strongly recommend a fluoride treatment every 6 months through the age of 18; however, some insurance companies may not cover this due either frequency or age limitations. Based on your current insurance coverage information below, is it okay for your child to receive a fluoride treatment today? Y / N

   _______*Your child's fluoride treatment should be covered today.**

   _______*Your child's fluoride treatment will be an out of pocket cost, at $_______ . We will bill to insurance first to confirm coverage, and send you a bill for any balance after insurance makes that determination.*

2. Does your child have any specific health conditions? Y / N

   Conditions: ____

3. Is your child currently taking any short-term medication? Y / N

   Medications:____

4. Is your child currently taking any long-term medication? Y / N

   Medications: ____

5. Does your child have any drug allergies? Y / N

   Allergies: ____

6. Does your child have any other allergies? Y / N

   Allergies: ____

7. Is your child experiencing any dental pain today? Y / N

   Describe: ____Severity: ____Low ____Medium ____High

8. Has your child had any dental problems/concerns since his/her last visit? Y / N

   Describe: ____

9. Anything specific you would like the doctor/assistant to discuss with your child? Y / N

   Describe: ____

***Periodic Exam Financial Coverage Agreement:**

I understand that today's visit will include a periodic exam and cleaning (prophylaxis). It may also include a fluoride treatment and x-rays. If my current insurance policy does not cover all or part of these services for any reason, or if my listed insurance policy is terminated and no updated insurance information is provided, I understand that I am fully responsible for any balance due to my account. I also understand that if my insurance policy does not cover today's visit at 100%, my copayment may be collected at the end of today's visit, or I will be billed after the insurance payment has been received. If I do not have insurance, I understand that my balance is due in full today.

Parent/Legal Guardian Signature: ____Date: ______________________