West Metro Pediatric Dentistry Health Update Form

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

Parent/Guardian at today's visit: _____ Relationship*: _____

**This health update must be completed by a legal guardian. If you are not this child's legal guardian, please let us know.*

1. Current contact information:

   Primary Parent/Guardian Cell: _____ Secondary Parent/Guardian Cell: _____

   Primary Parent/Guardian 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 for your child. However, some insurance companies may not cover this due either frequency or age limitations.

   Y◯ N◯Based on my current insurance coverage information below, it is okay for my child to receive a fluoride treatment today.

   Your child's fluoride treatment should be covered today. _____

   This coverage information does not include any deductibles that may need to be met before coverage is provided under some dental plans.

   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. Our doctors prescribe x-rays for your child based on their individual caries risk level, previous history, and American Academy of Pediatric Dentistry guidelines.

   Y◯ N◯f prescribed, it is okay for my child to have x-rays today.

3. Does your child have any specific health conditions? Y◯ N◯

   Conditions: _____

4. Is your child currently taking any short-term medication? Y◯ N◯

   Medications:_____

5. Is your child currently taking any long-term medication? Y◯ N◯

   Medications: _____

6. Does your child have any drug allergies? Y◯ N◯

   Allergies: _____

7. Does your child have any other allergies? Y◯ N◯

   Allergies: _____

8. Is your child experiencing any dental pain today? Y◯ N◯

   Describe: _____Severity: ____Low ____Medium ____High

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

   Describe: _____

10. 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% for any reason, 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: _____