West Metro Pediatric Dentistry Health Update Form

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.*			
Primary Parent/Guardian Cell:		Secondary Parent/Guardian Cell:	
Family Email Address:		Do you prefer text, email, or phone calls?	
Has your mailing address changed?	Y / N	If yes, please update:	
Has your insurance changed?	Y / N	If yes, new insurance company/ID #/Group #:	
Please only complete the above section once per family.			

Child's Name:		Nickname:		Birthdate:	/ /
Does your child any specific health conditions?	Y / N	If yes:			
Is your child taking any short- or long-term medications?	Y / N	If yes:			
Does your child have any drug or other allergies?	Y / N	If yes:			
Any dental pain/problems/concerns for your child?	Y / N	If yes:			
Anything specific you want us to discuss with your child?	Y / N	If yes:			

Our doctors prescribe x-rays based on individual caries risk levels, previous history, and American Academy of Pediatric Dentistry guidelines. **If prescribed, is it okay for your child to have x-rays today?**	Y / N
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.** Based on the insurance information currently in our system, your child's fluoride treatment should be: ____ covered today _____an out of pocket cost of $_____ ***This coverage information does not include any deductibles that may need to be met before coverage is provided under some dental plans. We will bill to insurance first to confirm coverage, and send you a bill for any balance after insurance makes that determination.* **Based on this information, is a fluoride treatment okay for your child today?**	Y / N

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:		Today's Date:	/ /

Thank for completing this form—we appreciate your time! Sections below are for administrative purposes.

Treatment Needed _____**No TX Needed**

Referred To

Reason:

Products/Prescriptions

Med Alerts Updated

Completed Today

___Per Ex ___Occ
___Px ___Bwx
___Tb Px ___PA
___Flz Var ___Pano
___Flz Foam
Other

Office Only:

___email updated
___phone updated
___insur updated
___letters completed