NEWPARK ORTHODONTICS

MEDICAL HISTORY UPDATE

All questions contained on this form are strictly confidential and will become part of the patient's record.

Please indicate changes to the following (check all that apply):

☐ADDRESS/PHONE/EMAIL ☐MARITAL STATUS ☐INSURANCE ☐PRIMARY GUARDIANSHIP ☐MEDICAL HISTORY

PATIENT INFORMATION:

Child's Last name: _____First name:_____ Middle initial: _____
Date of Birth: _____ Sex: Male 5 Female 5 Social Security #: _____ - ____ - _____
School: _____ Grade: _____
E-mail address: _____
Would you like appointment reminders via email? ☐Yes ☐No

Home address: _____City: _____ State: _____ Zip code: _____
Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (____)_____
Marital Status: _____
Primary Guardianship: _____

MEDICAL HISTORY: (please check all that applies)

Does the patient have any medical conditions? ☐Yes ☐No *(For example: ADHD, Asthma, Autism, Cerebral Palsy, Diabetes, Epilepsy, Seasonal allergies, etc.)* If YES, what conditions: _____

Does the patient have any HEART conditions? ☐Yes ☐No (For example: Heart Murmur, Congenital Heart Defect, etc.)
If YES, what conditions: _____

Does the patient require an ANTIBIOTIC before being seen? ☐Yes ☐No
If YES, did the patient take the antibiotic? ☐Yes ☐No

Does the patient have an ALLERGY to LATEX? ☐Yes ☐No

Does the patient have any OTHER ALLERGIES? ☐Yes ☐No
If YES, what allergies: _____

Is the patient currently taking ANY medications/ vitamins? ☐Yes ☐No
If YES, what medications/vitamins: _____
_____
Why is the patient taking this medication (i.e., what condition is it for): _____
_____

Do you (or the patient) have any DENTAL CONERNS? ☐Yes: ☐No
If YES, what concerns do you have? _____

I certify that the information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly Newpark Orthodontics all insurance payments otherwise payable to me. I understand that I am responsible for the full balance of account regardless of my dental benefits. In case of default, I agree to pay all reasonable cost and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees, and attorney fees.

I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold the dentist of any member of the staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. **I affirm that my signature represents my agreement to all the above mentioned terms.**

Signature: _____ Date: _____