

Medical History Update

Patient Name: _____

Address Change: _____

Preferred Phone Contact: _____

Preferred Email Contact: _____

Medical History Changes or Updates: _____

New medications? Yes No List: _____

Currently under physician's care? Yes No Explain: _____

Growth information for Patients Under 16 years of Age

Girl: Has she started menstruation? Yes No If Yes, When? _____

Boys: Has his voice changed? Yes No If Yes, When? _____

Orthodontic Dental Concerns _____

If you have any changes to your dental insurance, check here and notify front desk