Serengeti Smiles Pediatric Dentistry
Record Update

Child's Name_____ D.O.B_____

******Has the patient had any fever in the last 24 hours? Yes □ No □******

Has there been any change in patient's health since last dental appointment? Yes□ No□
If yes, please describe _____

Is your child ALLERGIC to any drugs or medications? Yes □ No □
If yes, please list: _____

Is the patient taking ANY medications? Yes□ No□
If yes, please list: _____

Has patient been recently diagnosed with any medical conditions? Yes□ No□
If yes, please list: _____

Do you have any particular concern(s) for the visit? _____

Has the patient been to another dental office since their last visit to our office? Yes□ No□

Is your child ALLERGIC to:

□ Latex	**□ Dental Anesthetics (Novocain)**
□ Nickel	**□ Food Allergies**

If yes, please list: _____ Other: _____

Does your child have a History of Acid Reflux? Yes □ No □
If yes, please explain: _____

Parent/ Guardian Information:

Name_____ SS#_____ D.O. B_____

Address: _____
Street: City: State: Zip:

Phone: _____
Home: Cell: (Cell is Required)

******* E-Mail Address is REQUIRED: _____**

Insurance:

Policy Holder Name: _____ SS#_____ D.O.B _____

Policy Holder's Employer: _____ Insurance Co. Name_____

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DOES CHILD HAVE SECONDARY INSURANCE COVERAGE? YES □ NO □

******Has your child ever had or currently has one the following******

Please check YES or NO	Yes	No	Please check YES or NO	Yes	No
Allergies			Epilepsy		
Asthma			Fainting		
Anemia			Hearing loss/ Speech disorder		
AIDS			Hepatitis		
Blood Disorder			Kidney Disorders		
Bleeding Disorder			Liver Disease		
Cancer			Lung Disease		
Cerebral Palsy			Mental/ Behavioral disorder		
Congenital Heart Defect/ Murmur			Rheumatic Fever		
Convulsions			HIV Positive		
Diabetes			Tuberculosis		

Child's Name: _____ D.O.B_____

Parent or Legal Guardian's Printed Name: _____

I hereby authorize the following person(s) to seek dental services and treatment for my child as recommended or provided by Dr. E Dale Martin, Dr. Camille LaHue, & Dr. Sarah Shin-Kim.

Printed Name/ Relationship/ Phone Number:

- _____
- _____

You must choose one of the following in order for form to be valid.

For the following period: _____through_____

□ Until such time as this authorization is revoked in writing.

Signature: _____ Date: _____

********You will be asked to complete a NEW one every 12 months********