JERSEY CITY PEDIATRIC DENTISTRY
RETURNING PATIENT UPDATE FORM

Patient's Name: _____ Date of Birth: ____/____/____ ☐ Male ☐ Female

CONTACT INFORMATION

Home Address ☐Same ☐New Address _____
Street City St Zip

Phone Number ☐Same ☐New Number _____

Email Address ☐Same ☐New Email _____

Has your dental insurance changed since we last saw you? ☐Same ☐ New If so please provide: _____

MEDICAL HISTORY UPDATE

Is your child taking a fluoride supplement? ☐Yes ☐No
Is your child taking any medications? ☐Yes ☐No If so please name _____
Has the dental health of your child changed since his/her last visit? ☐Yes ☐No If so please explain _____

Please circle Y or N regarding your child's history of the following:

Y N Allergies Environmental	Y N Diabetes	Y N Sickle Cell Disease
Y N Allergies Foods/Dyes	Y N Epilepsy/Seizures	Y N Sickle Cell Trait
Y N Allergies Medications	Y N Growth/Develop Problems	Y N Snoring/Sleep Apnea
Y N Latex Allergy	Y N Hearing/Speech Problems	Y N Special Needs
Y N Anemia/Bleeding Problems	Y N Heart Murmur/Disease	Y N Speech Problems
Y N Asthma	Y N Hepatitis/Liver Disease	Y N Stomach/Intestinal Disorder
Y N Autism/PDD	Y N HIV/AIDS	Y N Thyroid Problems
Y N Birth Defects/Disabilities	Y N Hyperactivity/ADD/ADHD	Y N Tuberculosis/Lung Disease
Y N Cancer/Tumors	Y N Kidney Disease	Y N Hospitalizations/Surgery
Y N Cleft Lip/Palate	Y N Rheumatic Fever	Y N Illness not listed

ACKNOWLEDGEMENT

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

Parent/Guardian Signature: _____

Print Name: _____Date:_____