Medical/Dental History Update

Child's Name: ____

Date of Birth:__ _________________________❑ Male ❑ Female

Lives with: ❑ Mother ❑ Father ❑ Legal Guardian ❑ Foster Parents

Name of person completing this form:________________________________ Relationship to Patient: ______________

Child's Physician/Office: ____ Physician's Phone: __________________

Preferred Pharmacy/Location: ____________________________________ Pharmacy Phone: __________________

Medical History: Has/Is your child:

A) Receiving any medication or drugs? ____

B) Under care for on-going condition(s)? ____

C) Ever been hospitalized/major surgery?____

D) Allergies: Food / Drug / Latex / Seasonal Please Explain: _______________________________

E) Other Updates? ____

Person(s) allowed to consent to treatment of patient (other than parent/guardian):

Name:____ Phone: ___________________________

Relationship to Patient: ____

Name:____ Phone: ___________________________

Relationship to Patient: ____

The undersigned parent(s) or guardian(s) of the minor patient authorizes the listed person(s) to consent to treatment of the minor patient. Signing of this consent will be giving permission for these adults to discuss your child's personal medical/dental history with the staff of Puget Sound Pediatric Dentistry as needed and to make medical/dental decisions for you regarding the dental care of your child when I am not available in person. It is understood that this consent is given in advance of any specific diagnosis or treatment being required and gives authority to the provider of care to diagnose and treat the minor in the parent/guardian's absence.

AUTHORIZATION: I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Since my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental service can be started. I grant Puget Sound Pediatric Dentistry consent to do an oral exam, take appropriate x-rays, clean the teeth, give a Fluoride treatment, and provide oral hygiene instructions, as deemed appropriate. I understand I will be consulted before any another treatment is rendered. I understand that this information will be used by our dentists to help determine the appropriate and ideal dental treatment. If there is any change in my child's medical status, I will inform the office immediately.

_________________________________ / _________________________________ ______________

Signature Print Name Date