Child's Update of Medical & Billing Information

Patient Name:

_____

Name of Parent/Guardian Filling Out This Form and Relationship to Patient:

_____

1. Has your child seen his/her physician since his/her last visit with us? *YES* *NO*
   - If so, what was the nature of your visit? _____
2. Has your child ever had any surgery? *YES* *NO*
   - If so, what was the nature of your surgery and when? _____
3. Please list any medications your child is allergic to: _____
4. Please list any medications (both prescription and over-the-counter) your child is taking and why:
   _____
5. Does you child need to take antibiotic premedication? *YES* *NO*
   - If yes, did he/she take it, what antibiotic, and how much? _____
6. Has your child ever had a diagnosis of tuberculosis, a persistent cough of greater than 3 weeks, or a cough that produces blood? *YES* *NO*

Please check all that apply to your child:

- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ HIV/AIDS
- ☐ Heart Murmur
- ☐ Hepatitis – Type _____
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tonsillitis
- ☐ Other _____

Our front desk will confirm all family and insurance information verbally

Parent/Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____