



Jason J. Sotto, D.M.D.

**Pediatric Dentistry
"Little Teeth, Big Smiles"**

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Patient Update form

1. Patient Information

Patient Name _____
Last First Mi

DOB: _____ Male Female

Address _____

Phone _____

Home _____ Cell _____

Email _____

New Insurance: Yes No

Insurance: _____

Phone #: _____

GRP #: _____

ID #: _____

Insured: _____

DOB: _____

SS #: _____

Employer: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

2. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian

Date

Relationship to Patient

3. Health History

Has the child ever had any of the following conditions?

- | | |
|--|--|
| Y N Abnormal Bleeding | Y N Handicaps/Disabilities |
| Y N Allergies to any Drugs | Y N Hearing Impairment |
| Y N Any Hospital Stays | Y N Heart Disease/Murmur |
| Y N Any Operations | Y N Hemophilia/Blood Disorders |
| Y N Asthma | Y N Hepatitis |
| Y N Cancer | Y N HIV + / AIDS |
| Y N Congenital Birth Defects | Y N Kidney/Liver Conditions |
| Y N Convulsions/Epilepsy | Y N Rheumatic/Scarlet Fever |
| Y N Pregnancy | Y N Allergies to Latex Product |
| Y N Tuberculosis | Y N Diabetes |

Please discuss any serious medical conditions the child has had

Please list all drugs the child is currently taking _____

Please list all drugs the child is allergic to _____

Child's Physician _____

Phone (_____) _____

Is the child currently under the care of a physician? **Yes** **No**

Please describe the child's current physical health...

Good

Fair

Poor