MEDICAL HISTORY UPDATE

All questions contained in this questionnaire are strictly confidential and will become part of the patient's record.

A Medical History Update must be provided once a year.

Patients Name: _____**Male or Female DOB:**_____

Patient's Primary Address: _____

Who does the patient live with? □ **Both Parents** □ **Mother** □ **Father** □ **Other:**_____

Parent's/Guardian's Name:_____

Home Number:_____ **Cell Number:** _____

Which number would you like to have patients confirmed? □ **Home** □ **Cell/ Mobile**

Email Address: _____

INDICATE CHANGES TO THE FOLLOWING (CHECK ALL THAT APPLY):

□ MARITAL STATUS □ INSURANCE □ ADDRESS/PHONE/EMAIL □PRIMARY GUARDIANSHIP □ MEDICATIONS

CONDITIONS	**Does the patient have any MEDICAL CONDITIONS?** □ Yes □ No (For example: ADHD, Asthma, Autism, Cerebral Palsy, Diabetes, Epilepsy, Seasonal Allergies, etc)
	If YES, what conditions?
	Does the patient have any HEART conditions? □ Yes □ No (For example: Heart murmur, congenital heart defect, etc.)
	If YES, what conditions?
	Does the patient require an ANTIBIOTIC before being seen? □ Yes □ No If YES, did the patient take the antibiotic? □ Yes □ No
ALLERGIES	**Does the patient have an ALLERGY to LATEX?** □ Yes □ No
	Does the patient have any other allergies? □ Yes □ No (For example: Animals, Foods, Medications, Nickel, etc.)
	If YES, what allergies?
MEDICATIONS	**Is the patient currently taking ANY medications/vitamins?** □ Yes □ No
	If YES, what medications/vitamins? Why is the patient taking this medication (i.e., what condition is it for)?
DENTAL CONCERNS	**Do you (or the patient) have any DENTAL CONCERNS?** □ Yes □ No
	If YES, what concerns do you have?

I certify that the information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patients medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign Seaside Children's Dentistry all insurance payments otherwise payable to me. I understand that I am responsible for the full balance of the account regardless of my dental benefits. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. We hope that both parents have equal access to the child, however, we know that is not always the case. We do not wish to include ourselves in this conflict, therefore, whichever parent that accompanies the child to their visit will be financially responsible. We will gladly accept prepayments from the other party.

I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold the dentist or any member of the staff responsible for any action they take or do not take because of errors or omissions that I may have madein the completion of this form. **I affirm that my signature represents my agreement to all the above mentioned terms.**

Signature: _____ **Date:** _____

SEASIDE
Children's Dentistry

Dental Records Release

Date of request _____

Please disclose my child's dental records & X-rays to

Seaside Children's Dentistry

Patient _____

Date of Birth_____

I, release _____from any laws related to disclosure of confidential of privileged information.

Signature

_____

Patient or person authorized to consent for patient

Address_____

Witness_____Date_____

info@seasidechildrensdentistry.net

1100-2 S. Ponce de Leon Blvd.
Saint Augustine, Florida 32084

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Authorization – Dental Care of a Minor when a Parent is not present

Patient:_____

Patient Date of Birth: _____

Person(s) I authorize to accompany my child:

Name_____Relationship to child: _____

Name _____ Relationship to child: _____

Name_____ Relationship to child: _____

I authorize Matt McLellan, DMD, Maria Fraser, DMD, and such assistants as he/she may designate, to render dental care to my child. I consent to any dental care which encompasses diagnostic or dental treatment which the dentist may deem necessary for my child's dental health and well-being.

This authorization will remain effective unless terminated by written notice.

Phone number where parent can be contacted during treatment, if needed:
Home: _____
Work: _____
Cell: _____

_____ _____
Signature of parent or legal representative Date

_____
Relationship to Patient

_____ _____
Witness Date