UPDATE FORM

Date _____ Patient Name_____ Date of Birth_____

Address _____City _____ State _____ Zip _____

Home Phone _____ Email address _____

Mother's Work Phone _____ Mother's Cell Phone _____

Father's Work Phone _____ Father's Cell Phone _____

Dental Insurance Company _____ Is this new? ☐ Yes ☐ No

Group Name _____ ID#_____ Phone#_____

Policy Holder: Name _____ Birthdate _____ SSN# _____

☐ Yes ☐ No Is your child in good health? Date of last physical exam_____

Name of child's physician _____Phone _____

☐ Yes ☐ No Has your child ever had a health problem?_____

☐ Yes ☐ No Has your child ever been hospitalized or had surgery?
Please give reason and dates_____

☐ Yes ☐ No Is there excessive bleeding when cut?

☐ Yes ☐ No Is your child allergic to anything? If so, what? _____

☐ Yes ☐ No Is your child currently taking any medications?
Please give medication and reason_____

☐ Yes ☐ No Were there any problems at birth?_____

Please answer each of the following. Has your child had any of the following health problems?

Heart disease ☐Yes ☐No	Bleeding/transfusions ☐Yes ☐No	Asthma ☐Yes ☐No	Blood dyscrasias ☐Yes ☐No
Tuberculosis ☐Yes ☐No	Liver/GI disease ☐Yes ☐No	Anemia ☐Yes ☐No	Diabetes ☐Yes ☐No
AIDS/HIV ☐Yes ☐No	Kidney Disease ☐Yes ☐No	Fainting ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No
Hepatitis ☐Yes ☐No	Mental delays ☐Yes ☐No	Seizures ☐Yes ☐No	Bladder Difficulties ☐Yes ☐No
Speech/hearing ☐Yes ☐No	Congenital birth defects ☐Yes ☐No	Thyroid Dz ☐Yes ☐No	Cleft lip/palate ☐Yes ☐No
Physical delays ☐Yes ☐No	Recurrent headaches ☐Yes ☐No	Chicken Pox ☐Yes ☐No	Frequent Infections ☐Yes ☐No
Personality/social ☐Yes ☐No	Drug/Alcohol abuse ☐Yes ☐No	Cancer ☐Yes ☐No	Measles/Mumps ☐Yes ☐No
Cerebral Palsy ☐Yes ☐No	Autism/Asperger ☐Yes ☐No	Other problems: _____	

I request and authorize Hilgers Pediatric Dentistry to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by the treating dentist to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Hilgers Pediatric Dentistry will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

If covered by insurance, I assign directly to Hilgers Pediatric Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and agree to reimburse Hilgers Pediatric Dentistry the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees Hilgers Pediatric Dentistry incurs in such collection efforts. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Parent/Guardian Signature: _____ Date: _____
Relationship to Patient: _____