Office Used Only:
Pt's weight:
Pt's age:

Update Sheet

Patient's Name:____Date of Birth:_______________________

Phone Number: (Home) __________________(Mobile) _______________Email: ________________________

Home Address: ____________________________Apt#_____ City:___________State:___Zip:___________

Reason for today's visit: ______________________________________

Diet: [ ] Vegetarian [ ] Mixed [ ] Special diet
Juice: [ ] More than 3 cups per day [ ] 2 cups per day [ ] Less than 1 cup per day
Snacking: [ ] More than 3 per day [ ] 2 times per day [ ] 1 time per day [ ] No Snacks
Brushing: [ ] 2 times per day [ ] 1 time per day [ ] Few times per week
Flossing: [ ] Everyday [ ] Few days per week [ ] Rarely [ ] Never
Do you use Fluoride Tooth Paste: [ ] we use [ ] don't use [ ] Rarely [ ] Never

Questionnaire:

1. Please indicate any health updates (health conditions) regarding your child. This will help us better serve your child: ____ ; Medications taken:______________________________

2. Does patient have any health problems? [ ] YES [ ] NO Explain:_____________________________________

3. Has patient been hospitalized? [ ] YES [ ] NO Explain:____

4. Has patient had any injuries to the mouth or teeth? [ ] YES [ ] NO Explain:_____________________________

5. Does patient have a toothache today [ ] YES [ ] NO Explain: ____

6. Has patient ever had any drug reactions, or is **allergic to anything?** such as materials commonly used in a dental office? [ ] YES [ ] NO Explain:______________________________

CONSENT FOR TREATMENT: I certify that I am the patient or parent/legal guardian of the patient listed above and the information provided in this form is true and correct to the best of my knowledge. By signing the form below, I give consent to Little Pearls Pediatric Dentistry to perform diagnostic/preventive procedures (X-rays and cleaning). After consultation regarding the treatment plan, I give consent to all required treatment and understand that I am responsible for any portion of the payment that is patient's responsibility.

Parent/guardian signature: ____________________________________Date:____________________

Relationship to Patient: ____

Dentist Signature: ____ Date:____________________