Pediatric Dentistry of Greenwood, P.A.

Jennifer B. Turner, D.M.D.

PATIENT UPDATE

PLEASE HELP US KEEP OUR RECORDS OF YOUR CHILD CURRENT

CHILD'S NAME_____ **CURRENT AGE**_____

PARENT'S NAME_____

FAMILY RECORD UPDATE

1. Please complete the following:
   *Address _____
   *Home Phone _____ *Cell Phone _____
   *E-mail Address _____

2. Your Employer:_____
   Spouse's Employer:_____

3. Has your dental insurance carrier changed? No _____ Yes _____
   New Carrier _____

MEDICAL UPDATE	Yes	No
1. Does your child have a medical condition(s) Dr. Turner should be aware of? What? _____	☐	☐
2. Is your child allergic to any medicines or foods? What? _____	☐	☐
3. Has there been any change in your child's health or medical history since their last dental visit? What? _____	☐	☐
4. Is your child taking any medications, prescription or over the counter? List _____	☐	☐
5. Have there been any injuries to the teeth, head or neck since the last visit? Explain _____	☐	☐
6. Is there any condition or problem you wish to bring to the attention of Dr Turner? _____	☐	☐

By signing this form I acknowledge the above information is correct and understand that all appointments are to be confirmed by noon one working business day before patients scheduled appointment.

Signature _____

Relationship to child _____ Date _____