

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: _____ Occupation _____

Spouse's Employer: _____ Occupation _____

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? _____

Signature _____

Relationship to child _____ Date _____