CERTIFICATION

To the best of my knowledge, the information I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Parent, Guardian or Personal Representative ____________ Date ____________

Please print name of Parent, Guardian or Personal Representative ____________ Relationship to Patient ____________

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? ____________

Is the patient taking any new medications? ____________ If so, what? ____________

Date ____________ Patient Signature ____________

Date ____________ Dentist Signature ____________

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? ____________

Is the patient taking any new medications? ____________ If so, what? ____________

Date ____________ Patient Signature ____________

Date ____________ Dentist Signature ____________

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? ____________

Is the patient taking any new medications? ____________ If so, what? ____________

Date ____________ Patient Signature ____________

Date ____________ Dentist Signature ____________

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? ____________

Is the patient taking any new medications? ____________ If so, what? ____________

Date ____________ Patient Signature ____________

Date ____________ Dentist Signature ____________