RECARE UPDATE

Dear Parents,

To ensure that we have up-to-date medical information, we are required to obtain the following information *every six months* or sooner if a major medical change has taken place. Thank you for taking the time to answer the following questions.

Child's Name: _____DOB: _____Age:_____
Address:_____ZIP:_____
Parent's Name:_____E-mail address:_____
Home phone #:_____Cell phone #:_____

1. Name of **physician** and phone number:_____
2. Has your child's **medical history** changed since your last visit?_____
If yes, please explain:_____
3. Is your child taking any **medication** at the present time?_____
If yes, please explain:_____
4. Is your child **currently undergoing** any medical treatment?_____
If yes, please explain:_____
5. Does your child have any **heart** related conditions [ex. Heart murmur]?_____
If yes, please explain:_____
6. Does your child have any **health problems** that need further clarification?_____
If yes, please explain:_____
7. Is your child **allergic** to any medications, dyes, food, flavors or LATEX?_____
If yes, please list:_____
8. Has your child had any **injuries/accidents** involving the head, face, or teeth
Since our last visit?_____
9. Are there any **dental related questions** that need to be discussed with the
Dentist?_____
10. **Siblings names** and ages:_____

What do you like most about our office?_____
Have there been any **CHANGES to your insurance** since your last visit? IF YES, please furnish a copy of the insurance card. Insurance Company:_____
Subscriber ID:_____
Name of Employer: _____
Address of Insurance Co. _____Phone#_____

I CERTIFY THE ABOVE INFORMATION IS CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION COULD BE DANGEROUS TO MY CHILD'S HEALTH. I AUTHORIZE THE CHILDREN'S DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO MY CHILD DURING SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS.

Signature:_____Relationship to patient:_____
Date:_____Doctor's Signature:_____

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