-Welcome Back-

We would like to welcome you and your child back to our office. It has been awhile since your last visit and in order to provide excellent service, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Update Patient Information

Name_____ **What would you like to be called?** _____
(First) (Middle) (Last)

Birth Date: _____/_____/_____ **Home Address:** _____

City: _____ **State:** _____ **Zip Code:** _____

Financial Responsible Party Name: _____ **Email:** _____

Financial Responsible Party Phone number: (_____)_____ **Type: (Circle One) CELL HOME WORK**

Relationship to patient: _____

If you have new dental insurance for your child, please fill out below.

Policy Holder Name:_____**Policy ID:** _____ **Birth Date**_____/ _____/_____

Ins. Name: _____**Ins. Phone Number:** _____ **ID #:** _____

Group #: _____ **Insurance Address:** _____
(Street) (City) (State) (Zip)

Patients General Dentist:_____ **Last Dental Visit:**_____

Medical Information

Physician: _____ **Phone Number:** _____
History of major illness? Yes No If yes, please describe:_____
Are you currently under the care of a physician: Yes No if yes, for what reason: _____
Taking Medication: Yes No If yes please list: _____
Allergic to any Medication: Yes No If yes, please list: _____
Allergic to anything else: Yes No If yes, please explain: _____
Has/Had or Have any: (circle all that apply)

Anemia	Chronic Illness	Hospitalization	Heart Disorder
Asthma	Convulsions	Hyperactivity	Heart Trouble
AIDS/HIV	Diabetes	Illness in Infancy	Hepatitis
Bleeding Problems	Emotional Problems	Learning Difficulty	Mental Disorder
Birth Defects	Epilepsy/Seizures	Liver Disease	Milk Allergy
Rheumatic Fever	Speech Impediment	Surgery	Tuberculosis
Tumors/Cancer	Sickle Cell Anemia	Osteoporosis	Arthritis

Please explain any other problems: _____
_____

Dental Information

Is there now or has there ever been any of the following: (circle all that apply)

Pain of the TMJ	Oral Habits	Cavities	Toothache
Extracted Teeth	Injured Teeth	Braces	Gum Disease
Thumb Sucking	Lip Biting/ Sucking	Missing or extra teeth	Unfavorable Experiences

Explain any issues: _____
_____

Signature

I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of nay changes in my child's medical status. I hereby authorize release of any information related to insurance claim. I consent to examination any treatment from the office of Dr. Brian St. Louis.

Signature: _____ **Date:** _____