



**Information Update**  
**MUST BE COMPLETED EVERY 6 MONTHS.**

To assist us in keeping your child's records current, please answer the following questions.

ATLANTA  
PEDIATRIC  
DENTAL  
SEDATION  
CENTER

**CHILD's** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Gender: **M** **F** Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
School District: \_\_\_\_\_

**Please list other siblings that are patients in our office (first and last names, please):**

CHILD's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
CHILD's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
CHILD's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary **Medical** Insurance name \_\_\_\_\_  
Secondary **Medical** Insurance name \_\_\_\_\_  
Primary **Dental** Insurance Company: \_\_\_\_\_  
Subscriber (Name insurance is under): \_\_\_\_\_  
Name of Employer (of the insured): \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Secondary Dental Insurance Company: \_\_\_\_\_  
Subscriber (Name insurance is under): \_\_\_\_\_  
Name of Employer (of the insured): \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**Do any of the following pertain to your child?**

	<b>YES</b>	<b>NO</b>
Heart Murmur Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Anemia/ Trait/ Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever/Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ ADHD	<input type="checkbox"/>	<input type="checkbox"/>
A.I.D.S / H.I.V. Positive/ Exposure	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral/ Learning Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>

**Is the PATIENT pregnant, or is there a chance she could be pregnant?** Yes \_\_\_\_\_ No \_\_\_\_\_

Is your child taking any medications at this time? If yes, please list: \_\_\_\_\_

Has your child been hospitalized within the last year? If yes, please explain: \_\_\_\_\_

Is there any other medical information we should be aware of? If so, please list: \_\_\_\_\_

Child's Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Approximate date of last visit to the pediatrician: \_\_\_\_\_

**Your Name (printed):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_