Orange County
Pediatric Dentistry
Dr. Dayna Olstein
Dr. Arielle Rolon

Health History Update

PATIENT INFORMATION

First Name		MI		Last Name	
Birth Date		Cell Phone		Home Phone	
Email Address					

INSURANCE INFORMATION

Have there been any changes to insurance information since your last visit? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY				SECONDARY DENTAL INSURANCE COMPANY			
Primary Policy Holder	First Last			Primary Policy Holder	First Last		
Relation		Gender	❑ Male ❑ Female	Relation		Gender	❑ Male ❑ Female
S.S. #		Birth Date		S.S. #		Birth Date	
Address				Address			
City		State	ZIP Code	City		State	ZIP Code
Telephone				Telephone			
Primary Policy Holder Employer				Primary Policy Holder Employer			
Business Address				Business Address			
City		State	ZIP Code	City		State	ZIP Code
Business Telephone				Business Telephone			
Insurance Co. Name				Insurance Co. Name			
Address				Address			
City		State	ZIP Code	City		State	ZIP Code
Telephone				Telephone			
Policy I.D. #				Policy I.D. #			
Group #		Plan Name		Group #		Plan Name	

HEALTH HISTORY

Question	Yes	No
Has your child received the MMR vaccine?	❑ Yes	❑ No
Since your child's last visit or exam have they had any new diagnosed medical problems?	❑ Yes	❑ No
If so, please explain		
Since your child's last visit have they had any surgeries?	❑ Yes	❑ No
If so, please explain		
Since your child's last physical exam have there been any allergic reactions to medications?	❑ Yes	❑ No
If so, please list medication and the reaction		

Please list any other changes to your child's general health

FORM COMPLETION

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian		Date	

IF PATIENT IS A MINOR

Form signed by		Relationship to Patient	