Barefield
Pediatric Dentistry
Donna J. Barefield, DDS, MSD and Associates

Health History Update

Patient Name: _____ Date: _____

Please Update Your Address: _____

Phone Number: _____ Email: _____

1. Have there been any changes in your child's overall health? **Yes** ◯ **No** ◯

   If you answered Yes, please explain: _____

2. Is your child under the care of a physician for any medical issues? **Yes** ◯ **No** ◯

   If you answered Yes, please explain: _____

   Please write down the Name and Phone number for the Physician treating your child:

   Physician Name: _____ **Phone#** _____

3. Has your child been hospitalized or undergone any kind of surgery in the past 12 months? **Yes** ◯ **No** ◯

   If you answered Yes, please explain: _____

4. Is your child currently taking any medications? **Yes** ◯ **No** ◯

   If you answered Yes, please List all medications and the reason for taking them:

   ✓ _____
   ✓ _____
   ✓ _____

5. Is your child allergic to any food or medication? **Yes** ◯ **No** ◯

   If you answered yes, please explain: _____

6. Is there any other information not listed here that you consider important for us to know about?

   _____

Parent Signature: _____

Signature of dentist reviewing history: _____

For Staff Use Only

Submit

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