



Dr. Melissa McHenry

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Medical History Update

Today's Date: _____
Patient Name: _____ Patients Date of Birth: _____
Mother's Name: _____ Father's Name: _____
Mother's Phone: _____ Father's Phone: _____
Email Address(es): _____
New Address: _____
Dental Insurance Name: _____ ID#/SS#: _____
Insured's Name: _____ Employer: _____

Are there any concerns that you would like to have addressed at today's appointment?

Have there been any changes in your child's health In the last 6 months?

Are your child's immunizations up to date? _____

Is your child currently under the care of a physician for medical problems? If so, please explain.

Does your child have a heart condition? If so, does your physician require an antibiotic prior to dental treatment? _____

Does your child have any allergies to medication, food, latex, metal or acrylic?

Does your child have a history of diabetes, asthma, kidney or liver difficulties and/or bleeding?

Has your child had any accidents involving the head, face or teeth since their last visit?

List any medications that your child is taking.

Has your child recently been diagnosed with any disabilities or behavioral issues?

Does your child use water that is fluoridated or take any fluoride supplements? Y or N

Parents Signature: _____ Date: _____

Please provide the front desk with your current Insurance card. THANK YOU!!!