

BEACHSIDE PEDIATRIC DENTISTRY
Madeline M. Badalaty, D.M.D.
ANNUAL MEDICAL HISTORY UPDATE

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Birth Date: _____ Phone (Home): _____

Mom: Email: _____ Work: _____ Ext: _____ Cell _____

Dad: Work: _____ Ext: _____ Cell Phone _____

Address: _____
Street Apartment #

_____ City State Zip Code

Health Information

Please check those that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Autism | <input type="checkbox"/> None |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> ADD | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> PDD | |
| | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> ADHD | |

- Have you or anyone in your household tested positive for COVID-19? Yes No If so, when? _____
- Have you been admitted to a hospital or needed emergency care during the past three years? Yes No
If yes, please explain: _____
- Is your child taking any medications? Yes No
If yes, please explain: _____
- Any Dental Concerns: _____

Dental Ins. Carrier _____ **Policy #** _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Because _____ is a minor, it is necessary that signed Permission be obtained from a parent or guardian before dental treatment is initiated. Therefore, I authorize the doctor and the dental staff to perform the necessary dental services my child may require. Furthermore, I will be responsible for any fee incurred of the above-named child for dental services rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

The parent that accompanies the child for their dental visit is responsible for payment for services rendered.

 Signature of patient, parent or guardian Date: _____
