THERESA M. WHITE, DDS, MS
SOUTHWEST PEDIATRIC DENTAL ASSOCIATES, PLLC
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PHONE 405.616.7336 FAX 405.616.5756

Patient Update Sheet Date____________________

Patient's Name____Age___________DOB___________
Last First MI

Patient Social Security Number____________________________Responsible Party________________________________

Address____ _____________ _____________ _____________
Number & Street City State Zip

Telephone_______________________________ ______________________________ ______________________________
Home Work Cell

Physician_____________________________Is child taking any medications?__________________________________

Has there been any change or addition in your insurance? Yes No

Name of Insured______________________________________DOB__________________SSN__________________

Name of Insurance ____________________________________Group or Policy Number__________________________

Does the patient receive state assistance? Yes No Do they have a current card? Yes No

DOES YOUR CHILD HAVE A HISTORY OF THE FOLLOWING CONDITIONS?

☐ **There is no history of any of the problems below.**

Yes	No		Yes	No		Yes	No	
☐	☐	Rheumatic Fever	☐	☐	Hepatitis	☐	☐	Hearing Problems
☐	☐	Heart Problems	☐	☐	Diabetes	☐	☐	Speech Problems
☐	☐	Heart murmur	☐	☐	Tuberculosis	☐	☐	Emotional Difficulties
☐	☐	Sickle cell anemia	☐	☐	Kidney Disease	☐	☐	Mental Disorder
☐	☐	Bleeding problems	☐	☐	Skin Problems	☐	☐	Fainting or dizziness
☐	☐	Birth Defects	☐	☐	Anemia	☐	☐	Poor vision
☐	☐	Epilepsy or seizures	☐	☐	Cerebral Palsy	☐	☐	Bone / joint problems
☐	☐	Asthma / wheezing	☐	☐	Nose problems	☐	☐	Ear problems
☐	☐	Throat problems	☐	☐	HIV/AIDS	☐	☐	Latex Allergy
☐	☐	Abnormal number/color of teeth	☐	☐	Cancer	☐	☐	Allergies
☐	☐	Autism	☐	☐	Penicillin Allergy	☐	☐	Other:_______________

Is your child allergic to any medications? ____

Does your child have any hobbies or special interests?____

Is there any additional information which would allow us to better care for your child?_____________________

____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that the answers I have provided will be used by the dentist to determine the appropriate dental treatment for my child. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I agree to be responsible for payment of all services rendered in behalf of my dependents.

Signature____Date______________________________

THERESA M. WHITE, DDS, MS
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Patient Name:

FOR OFFICE USE ONLY

MOLARS: Right_________ Left____________ OB:_______%___ OJ:_______mm__
MIDLINE:______ CROWDING:_______________ CROSSBITE:_______________ wt:_________

X-rays Taken: Yes or No

X-ray Type and Tooth Number: _________________________________

Treatment Needed: ____

Next Visit: ____

Cleaned By: ____

Scribed By: ____

Examined By: ____