Patrick C. Creevan, D.D.S., Inc.
Patient History Update

Form on file: ____/____/_____
Today's date: _____

Patient's Name: _____ Nickname:_____ Birthday:_____
Interests/Hobbies/Clubs: _____ School: _____
Current medications, including over the counter: _____
Allergies to food or medicine (please note anaphylaxis if applicable):_____
Hospitalizations and/or surgeries (with month and year dates): _____
Diagnosis or difficulty with any of the following: Please mark Y or N for all below conditions

A.I.D.S./H.I.V.	Y N	Cardiac Disease/Heart	Y N	Hepatitis	Y N
ADD/ADHD	Y N	Cerebral Palsy	Y N	Immune Disorder	Y N
Anemia	Y N	Chemo/Radiation Therapy	Y N	Kidney Issues	Y N
Anxiety	Y N	Cystic Fibrosis	Y N	Liver Issues	Y N
Arthritis/Joints	Y N	Delayed Development	Y N	Heart Murmur	Y N
Asthma	Y N	Depression	Y N	Muscular Disorder	Y N
Autism	Y N	Diabetes	Y N	Premature Birth	Y N
Bladder	Y N	Down's Syndrome	Y N	Rheumatic Fever	Y N
Bleeding Disorder	Y N	Earaches/Infection	Y N	Speech Disorder	Y N
Bone Disorder	Y N	Eating Disorder	Y N	Sinusitis	Y N
Brain Injury	Y N	Emotional/School Problems	Y N	TMJ Problems	Y N
Bruising	Y N	Epilepsy/Seizures	Y N	Tuberculosis	Y N
Cancer	Y N	Hearing Impaired	Y N	Visually Impaired	Y N

Other:_____

Parent/Guardian Update:

Mother:_____ Cell phone: ( )____-_____ E-mail address:_____
Father:_____ Cell phone: ( )____-_____ E-mail address:_____
Our office has permission to use e-mail as a means of communication with you. Initial:_____
Parents are: Married___ Divorced___ Single___ Widowed___ Partners___ Other_____
Child lives with:_____ Person financially responsible for treatment:_____
Step-parent:_____ Cell phone: ( )____-_____ E-mail address:_____

Insurance Update: Please mark one option below.

- ☐ Insurance coverage has not changed since last dental visit, **verify only employer below**.
- ☐ Insurance coverage has changed, complete the information below.
- ☐ Additional insurance coverage has been added to existing coverage, complete the information below.
- ☐ No active dental coverage for the patient

Policy holder's Name:_____ Insurance Company: _____
Birthdate:____/____/_____ SSN:____-____-_____ (Required if you need assistance gathering your Group # or Member ID)
Is this insurance provided through an employer? Y N If so, name of **Employer**:_____
Group #:_____ Member ID:_____ Union Local #:_____

☐ Guardian and Insurance information applies to additional patient(s), named:_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's health status or contact information.
SIGNATURE:_____ **Print Name:**_____
Relationship to Patient:_____ **Date:** _____/_____/_____
[Office Use Only] Medical history reviewed verbally with parent/guardian for above patient: Initials:_____ Date: _____