FORT WORTH
pediatric
DENTISTRY

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Health Update Recare Consent

Child's Name:______________________ Date of Birth: ____________ Age:__________

Child's School:____________________ Grade:________ Pediatrician:______________

Does your child have any medical issues? Yes ☐ No ☐ Is your child seeing any other specialists? Yes ☐ No ☐

Has your child seen his/her physician since the last visit? Yes ☐ No ☐ If so, why?
____

Has your child's medical history changed since the last visit? Yes ☐ No ☐ If so, how?
____

Any surgical procedures, hospitalizations or emergency room visits? Yes ☐ No ☐ If so, please list.
____

Is your child taking any medications at the present time or regularly? Yes ☐ No ☐ If so, what and why?
____

Has your child been ill or run a fever in the last 24 hours? Yes ☐ No ☐
____

Has your child received any immunizations or blood transfusions within the last year? Yes ☐ No ☐ If so, please list.
____

Are your child's immunizations up to date? Yes ☐ No ☐

Any injury to head, neck or teeth in the last 6 months? Yes ☐ No ☐ If yes:
____

Cause of injury: ____

Any dental issues or concerns? Yes ☐ No ☐ If so, what?
____

Please check if patient is allergic to any of the following:

☐ Latex ☐ Antibiotics: list : ______________________ ☐ Red Dye ☐ Nuts __________

☐ Other: Please specify: ____

In order to continue to provide the best possible care for your children, we would appreciate any suggestions:
____

Printed Name: ______________________ Relationship to Child: ____________

Signature: ______________________ Date: ______________

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