

INDIANAPOLIS PEDIATRIC DENTISTRY
ERIN F. PHILLIPS, D.D.S. & KIRA STOCKTON, D.D.S.
PATIENT HISTORY UPDATE

Please indicate any changes for patient's account information

Patient's Name _____ Age _____
With whom does patient live? _____ (Name and relationship to patient)

Guardian #1 Name _____
Address _____ City _____ Zip _____
Home # _____ Cell # _____ Day time # _____

Guardian #2 Name _____
Address _____ City _____ Zip _____
Home # _____ Cell # _____ Day time # _____

Do you have new dental insurance? Yes _____ No _____ (Please provide updated info)

To assist us in keeping your child's medical history up to date, please answer the following:

Physician's Name _____ Phone # _____

1. Has your child's medical history changed in the past year? Yes _____ No _____
If so, how? _____
2. Is your child currently taking any medications (including Herbal or complimentary)?
Yes ___ No ___ If yes, what and why? _____
3. Has your child received any immunizations in the past year? Yes ___ No ___
If so, what? _____
4. Any injury to head, neck or teeth in the past 12 months? Yes _____ No _____
If so, what? _____
5. Dental or medical related concerns or problems _____

In order to continue providing the best care for your child please offer your comments below:

1. What do you like most about your experience in our office? _____

2. What would you suggest to improve our service in the future? _____

I authorize Indianapolis Pediatric Dentistry, and those parties acting on behalf of Indianapolis Pediatric Dentistry, to contact me with appointment reminders in the following manner(s):

- Phone (best # _____) Text (best # _____)
 Mail Email (provide email address) _____

I give Indianapolis Pediatric Dentistry permission to leave health information on my voicemail or answering machine.

I, being the guardian of the above patient, grant Indianapolis Pediatric Dentistry permission to provide my child with dental care and will be responsible for the total cost of the dental care. *I have reviewed the current Financial and Appointment Policy.*

Date _____ Signed _____ Relationship to Patient _____