



N E W P A R K
ORTHODONTICS

MEDICAL HISTORY UPDATE

*All questions contained on this form are strictly confidential and
will become part of the patient's record.*

Please indicate changes to the following (check all that apply):

ADDRESS/PHONE/EMAIL MARITAL STATUS INSURANCE PRIMARY GUARDIANSHIP MEDICAL HISTORY

PATIENT INFORMATION:

Child's Last name: _____ First name: _____ Middle initial: _____
Date of Birth: _____ Sex: Male Female Social Security #: _____ - _____ - _____
School: _____ Grade: _____
E-mail address: _____
Would you like appointment reminders via email? Yes No

Home address: _____ City: _____ State: _____ Zip code: _____
Home phone: (_____) _____ Cell phone: (_____) _____ Work phone: (_____) _____
Marital Status: _____
Primary Guardianship: _____

MEDICAL HISTORY: (please check all that applies)

Does the patient have any medical conditions? Yes No (For example: ADHD, Asthma, Autism, Cerebral Palsy, Diabetes, Epilepsy, Seasonal allergies, etc.) If YES, what conditions: _____

Does the patient have any HEART conditions? Yes No (For example: Heart Murmur, Congenital Heart Defect, etc.)
If YES, what conditions: _____

Does the patient require an ANTIBIOTIC before being seen? Yes No
If YES, did the patient take the antibiotic? Yes No

Does the patient have an ALLERGY to LATEX? Yes No

Does the patient have any OTHER ALLERGIES? Yes No
If YES, what allergies: _____

Is the patient currently taking ANY medications/ vitamins? Yes No
If YES, what medications/vitamins: _____

Why is the patient taking this medication (i.e., what condition is it for): _____

Do you (or the patient) have any DENTAL CONCERNS? Yes No
If YES, what concerns do you have? _____

Health History Update Forms

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