Georgia Department of Public Health
Chatham County
Health Department

PLEASE UPDATE YOUR CHILD'S INFORMATION AT EVERY VISIT

Child's Name_____**Date of Birth**_____

Mailing Address_____

Phone Number_____

Primary Care Doctor_____**Pharmacy**_____

	YES	NO
Does your child have a toothache or mouth pain? If yes, explain:	☐	☐
Has your child visited the doctor since last dental visit? If yes, explain:	☐	☐
Has your child been in the hospital? If yes, explain:	☐	☐
Has your child visited the emergency room? If yes, explain:	☐	☐
Has your child undergone any medical tests? If yes, explain:	☐	☐
Does your child have any allergies? If yes, explain:	☐	☐
Does your child take any medicine? If yes, list:	☐	☐
Does your child take any over the counter medications, supplements, or vitamins? If yes, list:	☐	☐
Have you been told your child must take medicine before dental treatment? If yes, explain:	☐	☐
Does your child use tobacco or Vape or Juul? If yes, explain:	☐	☐
Is your child pregnant? If yes, due date:	☐	☐
Is there any other information we need to know about your child's health? If yes, explain:	☐	☐
Do you have any questions about your child's teeth? If yes, please explain:	☐	☐

I verify that the above medical information is true and accurate to the best of my knowledge. I have read and understood the above information. I also understand that I have the right to ask questions about my child's care, and that I have the right to refuse any examination, treatment, or procedure.

Date:_____ **Signature:**_____ **Parent Legal Guardian**