Michael J. Hanna, DMD, Pediatric Dentistry, PC

Existing Patient Medical Update

Required every six months by State Regulations & Insurance

Patient Name_____Age_____Date-of-Birth_____

First Middle Last

Address_____

Cell Phone_____E-Mail_____

If the patient has secondary insurance, please list carrier name:_____

Group Number_____ID#_____

Date of last medical exam_____

Has the patient had:	Yes	No	Remarks
diagnosed behavior issues?			
illnesses? Please list.			
diagnosed allergies?			
latex sensitivity?			
medications? Please list.			
hospitalizations? List dates and reasons.			
oral habits? Please list.			
dental trauma? Please specify.			
a mouthguard? List sports played.			
artificial joints or implants? Please specify.			
orthodontic care? If yes, list name of orthodontist.			
fluoride toothpaste?			
fluoride supplements? List brand and dosage.			
pregnancy?			

How many times a day does the patient brush teeth? ☐ 1 ☐ 2 ☐ 3

How many times a day does the patient floss teeth? ☐ 1 ☐ 2 ☐ 3

Is there any other information you feel we should know?_____

Today we will complete a routine oral exam, cleaning, and fluoride treatment. Bitewings may be taken. A complimentary orthodontic evaluation is completed during the exam. I give my consent to treat the above-named patient. I understand that a copy of this office's Notice of Privacy Practices is available for me to review.

_____

Print Name Signature (Parent signature required if patient is under age 18) Date

_____

Dr. Michael Hanna