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Patient(s) Name(s): \_\_\_\_\_ Todays Date: \_\_\_\_\_

**Do you have a doctor preference:** Please circle one Yes or No. (Dr. Herrin, Dr. Prempeh)

**Changes to my child's medical history since their last visit:**

- No changes
- Changes are as follows:

\_\_\_\_\_  
\_\_\_\_\_

**Has your child been to an oral surgeon, orthodontist, or any other dental provider this year?**  No

Yes (please list doctor's information) \_\_\_\_\_  
\_\_\_\_\_

**Is your child taking any medications?**

- Child** is not taking any medications currently
- Medications** child is currently taking (please list all medications)

\_\_\_\_\_  
\_\_\_\_\_

**Does your child have any allergies? (Please circle) YES / NO**      **If yes, list below:**

\_\_\_\_\_  
\_\_\_\_\_

**Contact information must be provided:**

Number you like to receive **call** reminders: \_\_\_\_\_

Number you like to receive **text** reminders: \_\_\_\_\_

Alternate/Emergency#: \_\_\_\_\_

Email address: \_\_\_\_\_

**\*For any insurance changes we require full information at least 24 hours prior to the appointment to avoid any unnecessary out-of-pocket expense to you.**

**Demographic Updates:**

Address/appt#: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_