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 _____