OCEAN PEDIATRIC DENTAL ASSOCIATES
Elisa Velazquez, D.M.D, Matthew Sones, D.M.D, and Associates
ANNUAL MEDICAL HISTORY UPDATE

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Birth Date: _____ Phone (Home): _____

Mom: Email:_____ Work:_____ _____Ext:____ Cell _____

Dad: Work: _____ Ext: _____ Cell Phone _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Growths
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Autism
- ☐ ADD
- ☐ PDD
- ☐ ADHD
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Thyroid
- ☐ Penicillin Allergy
- ☐ Cerebral Palsy
- ☐ None

- Have you or anyone is your household tested positive for COVID-19? ☐ Yes ☐ No If so, when? _____
- Have you been admitted to a hospital or needed emergency care during the past three years? Yes No
  If yes, please explain: _____
- Is your child taking any medications? Yes No
  If yes, please explain: _____
- Any Dental Concerns: _____

Dental Ins. Carrier_____ **Policy #** _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Because _____is a minor, it is necessary that signed Permission be obtained from a parent or guardian before dental treatment is initiated. Therefore, I authorize the doctor and the dental staff to perform the necessary dental services my child may require. Furthermore, I will be responsible for any fee incurred of the above-named child for dental services rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of $40.00 will be charged to your account if referred to our collection agency.

The parent that accompanies the child for their dental visit is responsible for payment for services rendered.

_____ Date: _____
Signature of patient, parent or guardian