Michael A. Keller, D.D.S., P.C.

Dear Parents:

We are updating our files and need the following information.

Please complete one sheet for each child and return to the front desk before you leave today.

Date: _____ Patient's Date of Birth: _____

Patient's Name: _____

Mother's Name:_____

Address:_____
Street # City State Zip

Home Phone:_____ Work Phone: _____

Father's Name: _____

Address: _____
Street # City State Zip

Home Phone: _____ Work Phone: _____

E-Mail: _____

Do you have dental insurance? If so, please show us your card to update our files.

WHAT MEDICATIONS DOES YOUR CHILD TAKE ON A REGULAR BASIS:_____

DOES YOU CHILD HAVE ALLERGIES? ____Yes ____No IF YES, PLEASE EXPLAIN:_____

DOES YOUR CHILD HAVE OR HAS CHILD EVER HAD ANY OF THE FOLLOWING:

_____Asthma	_____Cleft Lip/Palate	_____Kidney Disease	_____Sleep Apnea/Snoring
_____Autism	_____Developmental Disorder	_____Lactose Intolerance	_____Speech Disorder
_____AIDS/HIV	_____Diabetes	_____Latex Allergy	_____Spina Bifida
_____Birth Defects	_____Emotional Disorder	_____Liver Disease	_____Syndrome_____
_____Blood Disorders	_____Epilepsy	_____Mental Disorder	_____TMJ/TMD
_____Behavioral or Learning Problem	_____Eye Problem	_____Nervous Disorder	_____Tuberculosis
_____Brain Injury	_____Heart Problem	_____Premature Birth	_____Visual Problem
_____Blood transfusion Date: _____	_____Heart Disease	_____Retardation	_____Other: _____
	_____Heart Murmur	_____Rheumatic Fever	_____
_____Cancer/Tumors	_____Hepatitis	_____Sickle Cell Disease/Trait	

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN BELOW:

Signature of parent or guardian_____ Date _____