



Medical Update form in Parent/Guardian Absence

Patients Name: \_\_\_\_\_

DOB: \_\_\_\_\_

I hereby authorize my child, \_\_\_\_\_, to arrive unaccompanied for his/her dental check-up/procedure.

**OR**

I hereby authorize, \_\_\_\_\_, to act in my behalf to obtain treatment for my child in my absence:

**Personal Information Update, if necessary:**

Address: \_\_\_\_\_

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

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_@\_\_\_\_\_

**Insurance Information Update, if necessary:**

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

ID#: \_\_\_\_\_

**Medical Information Update: REQUIRED**

1. Has there been any change in patient's health since last dental visit? (surgeries, new diagnosis, hospital visits) Yes: \_\_\_\_ No: \_\_\_\_ If so, explain:  
\_\_\_\_\_

2. Is patient taking any medications? Yes: \_\_\_\_ No: \_\_\_\_

Please list: \_\_\_\_\_

3. Any new allergies? Yes: \_\_\_\_ No: \_\_\_\_

Please list: \_\_\_\_\_

4. Does the patient have any serious health problems? Yes: \_\_\_\_ No: \_\_\_\_

Please explain: \_\_\_\_\_

Name of parent/guardian \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_

Date \_\_\_\_\_

Please email this completed form to [info@adavenpediatricdental.com](mailto:info@adavenpediatricdental.com) fax to (702) 492-7663 or bring to the appointment. Thank you.