



**DEBORAH A. ASHCRAFT, D.M.D., P.C.**  
**PEDIATRIC AND ADOLESCENT DENTISTRY**

**PERIODIC EXAM UPDATE**

Date: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

Child's Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

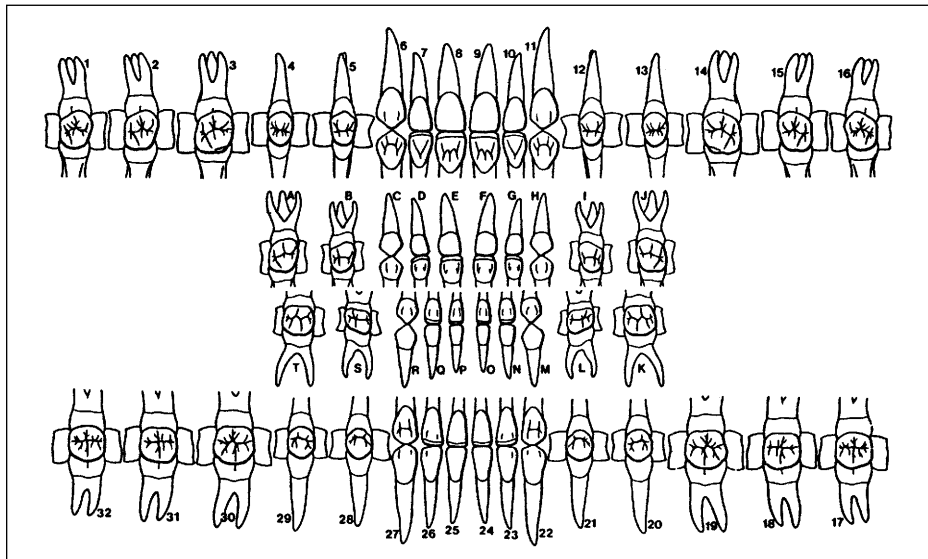
City/State/Zip Code \_\_\_\_\_

Home Phone # \_\_\_\_\_

Mother's Work # \_\_\_\_\_

Father's Work # \_\_\_\_\_

- 1) Is there a change in the mother's or father's place of employment?  Yes  No  
 New place of employment \_\_\_\_\_
- 2) Has his/her medical history changed since their last visit?  Yes  No  
 \_\_\_\_\_
- 3) Is he/she taking any medications at this time?  Yes  No If yes, what? \_\_\_\_\_  
 \_\_\_\_\_
- 4) Has he/she had any recent dental problems or habits – such as thumb, finger, or pacifier sucking habits?  
 Yes  No If yes, what? \_\_\_\_\_  
 \_\_\_\_\_
- 5) Is your child taking systemic fluoride supplements (tablets, drops or fluoride in vitamins)?  Yes  No
- 6) Has your dental insurance or payment method changed?  Yes  No
- 7) If the Dr. feels X-rays are needed at this visit, do we have your permission to take them?  Yes  No
- 8) Comments concerning your child's dental health?  
 \_\_\_\_\_  
 \_\_\_\_\_



Med Hx.: \_\_\_\_\_  
 Drug Allergies: \_\_\_\_\_  
 Soft Tissue: \_\_\_\_\_  
 OH: G F P  
 Gingivitis: \_\_\_\_\_  
 Calculus: \_\_\_\_\_  
 Habits: \_\_\_\_\_  
 Trauma: \_\_\_\_\_  
 Term Plane: R \_\_\_\_\_ L \_\_\_\_\_  
 Molar Rel: R \_\_\_\_\_ L \_\_\_\_\_  
 X Bite \_\_\_\_\_ Overbite \_\_\_\_\_ %  
 Overjet \_\_\_\_\_ mm Openbite \_\_\_\_\_ mm  
 Midline Dev. \_\_\_\_\_  
 TMJ Click: R \_\_\_\_\_ L \_\_\_\_\_

Thank you for your assistance in keeping our records up to date.

I authorize release of any necessary information to process insurance claims.

Please sign: \_\_\_\_\_ Date: \_\_\_\_\_