

CONTINUAL HEALTH STATUS FOR YOUR CHILD

____ Please check here if any changes listed below occurred since your last appointment.

Child's Name _____ Age _____

Parent's Name _____

Address _____ City _____ Zip _____

Home Phone _____

Mother's Current Employer _____ Work Ph. _____

Father's Current Employer _____ Work Ph. _____

*** Current Insurance Co. _____ Phone _____

Employee _____ Group No. _____

To assist us in keeping your child's medical history up to date, would you please answer the following questions:

1. Has your child seen his/her physician since your last visit? Yes ____ No ____
If so, why? _____

2. Has your child's medical history changed since last year? Yes ____ No ____
If so, why? _____

3. Is your child taking any medications at the present time? Yes ____ No ____
If so, why? _____

4. Has your child received any injections within the last year? Yes ____ No ____
If so, why? _____

5. Any injury to head or neck in the last 6 months? Yes ____ No ____
If so what? (ex: front teeth) _____

6. Any dental problems developed or developing that you are aware of? Yes ____ No ____

7. Other dental or medical related concerns or problems

Date: _____ Signature _____