

CHILDREN'S DENTAL CENTER

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CONTINUAL HEALTH STATUS REPORT

Child's Name _____ Age _____

Parent's Name _____

Address _____
(City) (Zip)

Home Phone _____

Mother's current employer _____ Work phone _____

Father's current employer _____ Work phone _____

Do you have Dental Insurance? Yes ___ No ___

Name of Carrier _____

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

1. Has your child's medical history changed since your last visit? Yes ___ No ___

If so, how? _____

2. Is your child taking any medication at the present time? Yes ___ No ___

If so, what and why? _____

3. Any injury to head or neck in last six months? Yes ___ No ___

If so, what? (ex. front teeth) _____

Cause of injury (ex. car accident, bike, door, etc.) _____

4. Any dental problems developed or developing that you are concerned about? Yes ___ No ___

If so, what? _____

5. Has your child ever had a blood transfusion? Yes ___ No ___

In order to continue to provide the best possible care to your children would you please offer your comments below:

1. What do you like the most about your treatment in our office? _____

2. What would you suggest to improve our service in the future? _____

Date _____ Signed _____