CHILDREN'S DENTAL CENTER

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1801 S. 5th Street, Suite 112 • McAllen, TX 78501

Continual Health Status Report

Child's Name _____Age_____Yrs. _____Mos.
Mother's Name _____
Father's Name _____
Address _____
Email _____
Home Phone_____ Cell Phone _____
Mother's Employer _____Work Ph._____
Father's Employer _____ Work Ph. _____

Does your child have Dental Insurance coverage? _____ Yes _____ No
Is your child covered under the Medicaid program _____ Yes _____ No
Name of Carrier _____

Name of child's pediatrician? _____
Phone # _____

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

I. Does your child have an existing medical condition? _____Yes _____ No
If so what?_____
2. Has your child's medical history changed since your last visit? _____ Yes _____ No
If so how?_____
3. Is your child taking any medication at this time? _____ Yes _____ No
If so what and why?_____
4. Is your child allergic to any medication? _____ Yes _____ No
If so, what medication? _____
5. Any injury to head, neck or teeth in the last six months? _____ Yes _____ No
Cause of injury? _____
6. Any dental problems developing that you are concerned about? _____ Yes _____ No
If so what? _____
7. Has your child ever had a blood transfusion? _____ Yes _____ No

8. What type of water does your child drink? _____ Tap _____ Filtered

In order to provide the best possible care to your child would you please offer your comments below?

1. What do you like most about your treatment in our office? _____
_____
2. What would you suggest to improve our service in the future? _____
_____

Date _____ Signature of person legally responsible _____