



Child's Name _____ Birthdate _____

Parent's Name _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

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

Has your child's medical history changed since your last visit? Yes__ No__

If so why? _____

Is your child taking any medications at the present time? Yes __ No__

If so what and why? _____

Have any dental problems developed or are developing that you are aware of? Yes__ No__

If so what? _____

Are there any other dental or health related concerns or problems? _____

Date _____

Signature _____