CONTINUAL HEALTH STATUS REPORT

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

Child Name(s): _____Date of Birth: _____

Parent/Legal Guardian in attendance today: _____ Relationship to Child: _____

☐ Yes ☐ No Have there been changes in your contact information? If so, please update.
Home Address: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

☐ Yes ☐ No Has your child seen a physician since your last visit? If so, why? _____

☐ Yes ☐ No Has your child's medical history changed since your last visit? If so, how? _____

☐ Yes ☐ No Does your child currently have a fever, strep throat, fever blister or cold sore? If so, which & what treatment has been administered?_____

☐ Yes ☐ No Is your child taking any medication at the present time?
What and why? _____

☐ Yes ☐ No Have there been any injuries to the head and neck in the last six months? If so, what? _____

☐ Yes ☐ No Are there any dental/medical concerns or problems developing that you are aware of?
If so, what? _____

☐ Yes ☐ No Are there any changes with your dental insurance? If so, please ask to complete a new insurance information sheet.

☐ Yes ☐ No Do you feel that you and your child are well-treated in our office? If not, why? _____

What do you like best about your treatment in our office? _____

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

☐ Yes ☐ No In the future, for appointment reminders, would you like to be contacted by email?

If yes, list your current email address _____

Signature: _____ Date: _____