Continual Health Status Report

Child's name: _____ Age: _____

Parent/Guardian who is accompanying child today: _____ Relationship: _____

☐ **Please check here if there are no changes in this section.**

Address: _____ Home Phone #: _____

_____

Father's employer: _____ Work #: _____ Ins. Co: _____

Mother's employer: _____ Work #: _____ Ins. Co: _____

Medical / Dental History

1. Is your child experiencing any pain today? Please circle severity (10-most severe) .....0 ▪ 1 ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6 ▪ 7 ▪ 8 ▪ 9 ▪ 10
2. Has your child seen his/her physician since the last visit here? ..... ☐ Yes ☐ No
3. Has your child's medical history changed since the last visit? ..... ☐ Yes ☐ No
4. Is your child currently taking any medications? If so, please list below. ..... ☐ Yes ☐ No
5. Has your child received any injections (including flu shots) within the last year? ..... ☐ Yes ☐ No
6. Is your child allergic to any medications, foods, environmental elements, animals? ..... ☐ Yes ☐ No
7. Any injury to the head or neck in the last 6 months? ..... ☐ Yes ☐ No
8. Have any dental problems developed since the last visit? ..... ☐ Yes ☐ No
9. Are there any other dental or medical concerns or problems? ..... ☐ Yes ☐ No

If you answered YES to any of the questions, please explain in detail: _____

_____

_____

Please read this next section carefully before signing.

I understand that today's services will include a periodic examination, a (prophylaxis) cleaning, fluoride treatment and/or x-rays. I am aware that the insurance policy on file with this office may have benefit, frequency and/or age limitations for these services and may deny partial or full payment. If any amount is not covered by the dental insurance, I understand that this balance will be my responsibility.

_____ _____ _____

Signature of Parent or Legal Guardian Date Staff Signature