Continuing Care Update

Child's Name_______________________________________ Date_______

So that we can continue to provide safe treatment and preventive care for your child, please complete the following:

Have there been any changes in your child's health since his/her last exam (i.e allergies, heart murmur, medical treatment, surgery)? ❒ Yes ❒ No

If yes, please describe____

____

Does your child take any medications? ❒ Yes ❒ No

If yes, please describe____

____

Has your child had any injuries involving the teeth, face, or head since the last dental visit? ❒ Yes ❒ No

If yes, please describe____

____

Is there any condition or problem you wish to bring to the Doctor's attention this visit? ❒ Yes ❒ No

If yes, please describe____

____

Cell Phone # ____________________ E-mail ________________________

Is there a change in your:

Address ❒ No ❒ Yes, changed to:____________________________

Phone Number ❒ No ❒ Yes, changed to:____________________________

Mother, Employer ❒ No ❒ Yes, changed to:____________________________

Father, Employer ❒ No ❒ Yes, changed to:____________________________

Dental Insurance ❒ No ❒ Yes, changed to:____________________________