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Periodic Health Review

Child's Name _____ Age _____

Parent's Name _____

Address _____

_____

Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Mother's current employer _____

Father's current employer _____

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

1. Has your child seen his/her physician since your last visit? Yes ____ No ____
   If so why? _____
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 the present time? Yes ____ No ____
   If so what and why? _____
4. Has your child received any injections within the last year? Yes ____ No ____
   If so what? _____
5. Any injury to head or neck in last 6 months? Yes ____ No ____
   If so what? (ex. front teeth) _____
   Cause of injury (ex. car accident, bike, door,etc.) _____
6. Any dental problems developed or developing that you are aware of? Yes ____ No ____
7. Other dental or medical related concerns or problems _____

In order to continue to provide the best possible care to your children, would you please offer your comments below:

1. Do you feel you and your child are well treated in our office? Yes ____ No ____
   If not, why not? _____
2. What do you like most about your treatment in our office? _____
3. What would you suggest to improve our service in the future? _____

Date _____ Signed _____

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