



Tyler Carter, DDS

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CONTINUAL HEALTH STATUS FOR YOUR CHILD

\_\_\_\_\_ Please check here if there have not been any changes

Child's Name \_\_\_\_\_ Age \_\_\_\_\_

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Current Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Employee \_\_\_\_\_ Group No \_\_\_\_\_

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

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 \_\_\_

Is so what and why? \_\_\_\_\_

Any injury to head or neck in the last 6 months? Yes \_\_\_ No \_\_\_

If so what? (ie: front teeth) \_\_\_\_\_

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 \_\_\_\_\_