

Children's Dental Village

Date: _____

Thank you for completing this form. It will help us give your child the best dental care possible and assist us in maintaining our records.

Child's Full Name

Age

Home Phone

Mailing Address

City

State

Zip Code

Family email address

Work/cell phone

ABOUT YOUR CHILD:

YES NO

Any significant medical history change or new allergies we should be aware of?

Is child taking any medications? _____

Any injuries to the head, face or teeth since the last visit?

Anything you need to discuss with the Doctor today?

ABOUT YOU:

YES NO

Has your marital status changed?

Dental insurance changed?

Employer or insured person changed?

Your printed name

Relationship to child

Signature