CHILDREN'S DENTAL VILLAGE

Patient's Full Name Age

Gender: Male ❑ Female ❑ Allergy to Tree Nuts: ❑ YES ❑ NO

Any changes to address/phone/email? ❑ YES ❑ NO
If Yes-please list new info:

Mailing Address, City, State, Zip (Mother/Guardian)

Mailing Address, City, State, Zip (Father/Guardian)

Family email address Home Phone

Cell Phone (Mother/Guardian) Cell Phone (Father/Guardian)

ABOUT THE PATIENT:

YES NO

❑ ❑ Have there been any significant medical changes or any allergies we should be aware of? _____

❑ ❑ Is your child taking any medications? If yes, what is the medication(s) and what is it for? _____

❑ ❑ Have there been injuries to the head, face or teeth since the last visit? _____

❑ ❑ Is there anything you need to discuss with the Doctor today? _____

PARENT/GUARDIAN INFORMATION:

YES NO

❑ ❑ Has there been a change in custodial or marital status?

❑ ❑ Has there been a change in dental insurance?

❑ ❑ Has your employer or insured person changed?

Your printed name Relationship to patient

Signature Date