RECALL FORM
All About Kids Pediatric Dentistry

Child's Name _____ Age: _____

Your Name _____ Parent Y / N

Your Relationship to the child; if not the parent _____

Address_____

City _____ State _____ Zip _____

Home Phone_____ Cell Phone_____
E-Mail_____
Mother's Employer_____ Work Phone_____
Father's Employer_____ Work Phone_____
Alternate Contact Name_____ Phone_____

Has your insurance information changed since the last visit? YES_____ NO_____
If yes, please give new information to front office staff.

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

1. Has your child seen his/her physician since your last visit? YES / NO
   If yes, who? _____
2. Please list any medical condition(s) your child may have _____
   _____
3. Is your child currently taking any medication? YES / NO
   If yes, please list: _____
   _____
4. Has your child received any injections within the last year? YES / NO
   If yes, what? _____
5. Any injury to the head or neck in the last 6 months? YES / NO
   If yes, what? _____
6. Any dental problems developed/developing that you are aware of? YES / NO
   If yes, what? _____
7. Please list any specefic concerns you would like to address with the doctor today

_____

Signed_____ Date_____

Dr. _____ Date _____