Recall Form

Child's Name_____ Age_____

Parent's Name_____

Address_____

Home Phone_____ Cell Phone_____

Mother Employer _____ Work Phone_____

Father 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, would you please answer the following questions:

1. Has your child seen his/her physician since your last visit? YES / NO
   If yes who?_____
2. Has your child's medical history changed since your last visit? YES / NO
   If yes what?_____
3. Is your child currently taking any medication? YES / NO
   If yes, what and why?_____
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 or developing that you are aware of?
   If yes, what?_____
7. Other dental or medical related concerns or problems_____

Signed_____ Date_____