CONTINUAL HEALTH STATUS REPORT

Child Name(s): _____Date of Birth: _____

Parent/Legal Guardian in attendance today: _____ Relationship to Child: _____

□ Yes □ No Have there been changes in your contact information? If so, please update.
Home Address: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

□ Yes □ No Has your child seen a physician since your last visit? If so, why? _____

□ Yes □ No Has your child's medical history changed since your last visit? If so, how? _____

□ Yes □ No Does your child currently have a fever, strep throat, fever blister or cold sore? If so, which & what treatment has been administered?_____

□ Yes □ No Is your child taking any medication at the present time?
What and why? _____

□ Yes □ No Have there been any injuries to the head and neck in the last six months? If so, what? _____

□ Yes □ No Are there any dental/medical concerns or problems developing that you are aware of?
If so, what? _____

□ Yes □ No Do you feel that you and your child are well-treated in our office? If not, why? _____

What do you like best about your treatment in our office? _____

What would you suggest to improve our service in the future? _____

*** If you do not currently receive appointment reminders, and would like to, please provide your preferred form on communication below?**

If yes, list your current email address _____ If yes, list your current cell phone number_____

How do you plan to pay for today's visit? □ Cash □Check □Visa □Master Card □Medicaid/NC Health Choice

□ Yes □ No Do you have dental insurance? If yes, we will ask to scan your insurance card.

Signature: _____ Date: _____

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