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

- Has your child seen his/her physician since their last visit?  
  Yes [ ] No [ ]
- Has your child’s medical history changed since their last visit?  
  Yes [ ] No [ ]
- Is your child taking any medication at this time?  
  Yes [ ] No [ ]
- Has your child received any injections within the last year?  
  Yes [ ] No [ ]
  o If so, what and when?____________________________________________________
- Has your child had any injury to head, neck, face, mouth/teeth in last 6 months? Yes [ ] No [ ]
  o If so, what area, ___________ Cause of injury? ____________________________
- Any current or past dental problems that you are aware of?  
  Yes [ ] No [ ]
  o If so, what___________________________________________________________
- Any other medical or dental related concerns or problems?________________________
  _______________________________________________________________________

In order to continue to provide the best possible service and care to you and your child, please take a moment to answer the questions below:

- Do you feel you and your child are treated well in our office? ______________________
- What do you like most about our office?
  o _______________________________________________________________
  o _______________________________________________________________
- What would you suggest to improve our service in the future?
  o _______________________________________________________________
  o _______________________________________________________________

Signature____________________________ Date___________________