Post Oak
Pediatric Dentistry

Child's Name_____ DOB_____ SSN_____

Parent/Guardian Name_____ Relationship_____

Home Address _____,_____,_____,_____

Home Phone _____ Email_____

Cell (Mom)_____ Work (Mom) _____

Cell (Dad)_____ Work(Dad) _____

Ins Co_____ ID#_____ Phone_____

Employer _____

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 [ ]
    - If so, what and when?_____
- Has your child had any injury to head, neck, face, mouth/teeth in last 6 months? Yes [ ] No [ ]
    - If so what area, _____ Cause of injury? _____
- Any current or past dental problems that you are aware of? Yes [ ] No [ ]
    - 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?
    - _____
    - _____
- What would you suggest to improve our service in the future?
    - _____
    - _____

Signature_____Date_____