Pediatric Dental Specialists, P.C.

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

Contact information: _____ _____ _____
home phone mobile phone e-mail

Have you had a change in address? YES NO If yes, please provide new mailing address

_____

Parent Marital Status (circle one): married single divorced other

Please list any dental insurance you will be using with your child:

_____

Have there been any changes in medical history OR severe illness? If yes, please explain:

_____

Are you experiencing any COVID-19 symptoms? _____

Is your child allergic to any medications? _____

Please list any prescription or over the counter medications your child is currently taking and why:

_____

Have there been any injuries to the teeth, head, or neck since the last visit?

_____

Is there any condition/problem you wish to bring to the doctor's attention?

_____

Signature_____ Date:_____

Relationship to patient:_____