Dr. Duga Dr. Feeney & Associates
Pediatric Dentistry

Continual Health Status Report

❑ **Please check here if any information below is new**

Child's Name____ Age____ yr ____ mo

School ____

Parent's Name ____

Address ____
(City) (Zip)

Email Address ____

Home Phone __________________________ Cell Phone __________________________

Mother's Current Employer ______________________________ Work Phone ___________

Father's Current Employer ______________________________ Work Phone ___________

To assist us in keeping your child's medical history up to date, would you please answer the following questions (use reverse side of form if needed):

1. Has your child seen his/her physician since your last visit? Yes_____ No ____
   If so, why? ____
2. Has your child's medical history changed since your last visit? Yes_____ No ____
   If so, how? ____
3. Is your child taking any medication at the present time? Yes_____ No ____
   If so, what and why? ____
4. Has your child received any injections within the last year? Yes_____ No ____
   If so, why? ____
5. Any injury to head or neck in last 6 months? Yes_____ No ____
   If so, what? (ex. front teeth) _______________________________________
   Cause of injury (ex. car accident, bike, door, etc.) ____________________
6. Any dental problems developed or developing that you are aware of? Yes_____ No ____
7. Do you have <u>NEW</u> insurance coverage? Yes_____ No ____
8. Other dental or medical related concerns or problems? _____________________
   ____

In order to continue to provide the best possible care of your children, would you please offer your comments below:

1. Do you feel you and your child are well-treated in our office? Yes_____ No ____
   If not, why not? ____
2. What do you like most about your treatment in our office? __________________
   ____
3. What would you suggest to improve our service in the future? _______________
   ____

I, being the parent or guardian of the above minor patient, do hereby authorize and request the performance of routine dental services for this patient. This includes examination of hard and soft tissue, cleaning, fluoride treatment, check and repair of sealants (if applicable) and necessary x-rays.

Date________________ Signed ____

Relationship _______________________________________

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