

Post Oak Pediatric Dentistry

Kids love us, Parents trust us

Child's Name _____ Age _____ Cell _____

Parent/Guardian Name _____ Relationship _____

Address _____

Street _____ City _____ State _____ Zip _____
Home Phone _____ Email _____

Cell (Mom) _____ Work (Mom) _____

Cell (Dad) _____ Work (Dad) _____

Ins Co _____ ID# _____ Phone _____

Employee _____ DOB _____ SS# _____

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 that last 6 months? Yes [] No []

If so what area, _____ Cause of injury? _____

Any dental problems that are developing or have developed that you are aware of? Yes [] No []

If so, what _____

Any other medical or dental related concerns or problems? _____

In order for us 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 _____