



Recall Form

Child's Name _____ Age _____

Parent's Name _____

Address _____

Home Phone _____ Cell Phone _____

Mother Employer _____ Work Phone _____

Father Employer _____ Work Phone _____

Alternate Contact Name _____ Phone _____

Has your insurance information changed since the last visit? YES NO

If yes, please give new information to front office staff.

To assist us in keeping your child's medical history up to date, would you please answer the following questions:

1. Has your child seen his/her physician since your last visit? YES / NO
If yes who? _____
2. Has your child's medical history changed since your last visit? YES / NO
If yes what? _____
3. Is your child currently taking any medication? YES / NO
If yes, what and why? _____
4. Has your child received any injections within the last year? YES / NO
If yes, what? _____
5. Any injury to the head or neck in the last 6 months? YES / NO
If yes, what? _____
6. Any dental problems developed or developing that you are aware of?
If yes, what? _____
7. Other dental or medical related concerns or problems _____

Signed _____ Date _____