Dental Recare Form

Patient Name: _____ **Today's Date:** _____
Last **First** **MI**

Has your information listed in BLUE below changed? □ If NO, please skip this area. □ If YES, please update.

Address: _____
Street # / Street Name City State Zip Code

MOM: Home#: _____ Work#: _____ Mobile#: _____

DAD: Home#: _____ Work#: _____ Mobile#: _____

MOM Email: _____ DAD Email: _____

Do you want to receive your "Appointment Confirmations" through email/text? □ Yes □ No

Insurance Update

Insurance Name: _____ Insured Employer: _____

Medical History

Has your child had any recent viruses or bacterial infections in the last month? □ Yes □ No

If yes, provide date and description: _____

Has your child been diagnosed with any medical conditions since your last visit? □ Yes □ No

If yes, provide date and description: _____

Is your child currently taking any medications / vitamins? □ Yes □ No

If yes, please list medications, dosages, date/time taken, and reason: _____

_____

Does your child have a peanut or nut allergy? □ Yes □ No If Yes, please list: _____

Please list what your child is drinking on a daily basis? _____

Dental History

Would you like your child to receive a letter grade on their oral hygiene report card? □ Yes □ No

Have there been any dental concerns or problems since the last visit? □ Yes □ No

If yes, please describe: _____

_____

To reduce patient wait time, are you willing to see the first available dentist for your childs exam? □Yes □No

PLEASE NOTE: "All Examinations" scheduled between 2:50pm-5:00pm are reserved for ONLY those patients willing to see the first available dentist.

PLEASE NOTIFY FRONT DESK IF YOU WILL BE LEAVING THE OFFICE DURING YOUR CHILD'S APPOINTMENT. WE MUST HAVE A CELL PHONE TO REACH YOU.

Parent/Guardian Signature: _____ **Date:** _____