

CORONA KIDS DENTAL PERIODIC EXAMINATION FORM

Thank you for taking a moment to update you and your child's information.
This is the correct form for you if your child has visited us within the last 18 months.
If not, please fill out the new patient registration form. Thank you.

Patient Name: ,
Last First MI Preferred Name

Yes No Has there been any change to your **phone numbers? Address? Or dental insurance?**

If you answered **YES** above, please ask us for a **NEW PATIENT REGISTRATION FORM** to update your information.

Yes No Has there been any change in your child's **health** status?

Yes No Has your child been under the care of a medical doctor for any reason since his or her last dental visit?

Yes No Is your child **allergic** to anything?

Yes No Is your child currently taking any **medications**?

If you have answered **YES** in any of the above, **please explain** here and notify the doctor:

Do you have any **specific concern** about your child's dental health?

If you could change anything about your child's mouth, teeth, or smile, what would it be?

Confirmation of Accuracy

Please check here and sign below to confirm that: "I am the parent or legal guardian (responsible party), and I confirm that all the preceding information (including but not limited to patient, insurance, parent/responsible party information, etc.) is true and correct. If there is ever a change in the preceding information, I will inform the office at my child's next dental appointment without fail."

Signature of parent, or legal guardian (Responsible Party):

X _____ / /
Print Name Signature Date

Doctor: _____
(Office use only)