Coastal Pediatric Dentistry

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CONTINUAL HEALTH STATUS REPORT

Child's Name _____ Age _____

Parent's Name _____

Relationship _____

Address _____

Billing Address (if different than above) _____

Home Phone _____ Father's Work Phone _____ Mother's Work Phone _____

Any New Dental Insurance _____ Address _____

Policy Holder's Name _____ Policy Holder's DOB _____

SS # _____ Cell Phone _____

Employer _____

Email _____

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 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, what? _____
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. Other dental or medical related concerns or problems: _____

In order to continue to provide the best possible care to 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? _____
2. What do you like most about your treatment in our office? _____
3. What would you suggest to improve our service in the future? _____
4. If your child has a very loose tooth, would you like us to remove it? ☐YES ☐NO

In an effort to reduce our billing costs so that we can keep our fees down, we require that your fees or estimated co-payments be made on the day of the appointment.

I will be paying today by:

☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ CARECREDIT ☐ MEDICAID

Date _____ Signed _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I Hereby authorize Dr. Robert Harrison D.M.D., M.S.D. to furnish information to insurance carriers concerning my dependent's treatments and I hereby assign to the dentist all payments for his services rendered to my dependents. I understand that I am responsible for any amount not covered by insurance.

DATE_____ SIGNATURE_____