Child Check-in Form

for

First Name _____ Last Name_____

Date of Birth _____ Today's Date _____

What is your relationship with the patient?

O Mother O Guardian
O Father O Other _____

Treatment today will include:

O Dental Cleaning **O Periodic Exam**
O Bitewing X-rays **O Panoramic X-ray**
O Fluoride Varnish Treatment **O Other _____**

Have there been any changes in her/his health? Yes No
If yes, please specify:

Patient's physician's name and date of last physical exam:

Is she/he taking any medications? Yes No
If yes, please list medications and reason for taking:

Does she/he have any allergies? Yes No
If yes, please specify:

Has she/he had any recent surgeries or hospitalizations? Yes No
If yes, please specify:

Is she/he having any dental issues? Yes No
If yes, please specify:

Is there anything else we should know before her/his visit?

Please sign here _____

Thank you
Suncook Dental
Staff Initials _____