Entered by_____
(office use only)

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 Name | First Name | MI | Preferred Name (if any)

☐Yes ☐No Has there been any change (or addition) to your **dental insurance** since your child's last visit?

☐Yes ☐No Has there been any change to your **phone numbers**? **address**? Or **e-mail**?

☐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 currently taking any **medications**?

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

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

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

Confirmation of Accuracy

Please 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)