CANDICE Z. HUTCHESON, DDS, MS
TERRI E. TRAIN, DDS, MS
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100 N. CENTRAL EXPWY, SUITE 1108, RICHARDSON, TX 75080
4443 N. JOSEY, SUITE 180, CARROLLTON, TX 75010

Child's Name ____ Age ________________

Parent's Name ____

Address ____

City ____Zip ________________

Home Phone: ___________________ E-mail: ___________________________________

Cell Phone: ______________________________

How do you prefer to be contacted for appointment confirmation?
Please check all that apply.

❑ phone call to #__________________________ ❑ e-mail to ___________________________

❑ text to mobile # _________________________*(charges may apply according to your plan).*

To assist us in keeping your child's medical history up to date, 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, why? ____

3. Is your child taking any medications at the present time? Yes _____ No _____

   If so, what and why? ____

   Is this a change in medication? Yes _____ No _____

4. Is your child up to date on vaccinations? Yes _____ No _____

5. Any injury to head or neck in the last 6 months? Yes _____ No _____

   If so, what? (ex. front teeth, concussion) ______________________________________

6 Any dental problems developed or developing that you are aware of ? Yes _____ No _____

7. Other dental or medical related concerns or problems ____________________________

   ____

8. Does your child have any allergies? Yes _____ No _____

   If yes, what? ____

9. Does your child have any heart problems? Yes _____ No _____

   If yes, explain ____

10 Has your child ever been informed that he/she needs prophylactic antibiotics prior to dental treatment? Yes _____ No _____

11 Pediatrician (Physician) ____

   ____

(Continued on Back)

In order to continue to provide the best possible care to your children, would you please offer your comments below:

1. Are there any personal or family challenges (including drug/alcohol abuse, depression/anxiety) that have occured in your child's life that you would like to share with us?__________________

____

2. Do you feel you and your child are treated well in this office ? Yes______ No_______
3. If not, why not?____

____

4. What do you like most about your treatment in our office?______________________________

____

____

5. What would you suggest to improve our service in the future?___________________________

____

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6. ***We would love to share how great your child is doing with our fans on our Social Media sites and need your approval to do so. Please check the appropriate boxes below with your preferences:***

- ❑ Name and Picture
- ❑ First name Only and Picture
- ❑ Picture Only
- ❑ No Picture or Name

5. AUTHORIZATION TO TREAT
I authorize Children's Dental Specialists to treat the above mentioned patient using restorative or oral surgery techniques as well as patient management techniques that are reasonable and necessary as the dentists deem advisable. I understand that the treatment plan presented, along with the fees outlined, could change depending upon the time elapsed since the examination and the extent of decay.

CONTINUAL HEALTH STATUS REPORT

A $25.00 Fee may be incurred without a 24hr notice of cancellation

____ ____________________

Patient/Parent Signature Date