

INDIANAPOLIS PEDIATRIC DENTISTRY
ERIN F. PHILLIPS, D.D.S. & VIRGINIA W. CROSE, D.D.S.
CONTINUAL HEALTH STATUS REPORT

Patient's Name _____ Age _____
Patient's Address _____ City _____ Zip _____
Patient's Home Phone# _____

Guardian #1 Name _____ Home # _____
Guardian #1 Address _____ City _____ Zip _____
Guardian #1 Employer _____
Workphone # _____ Cell# _____

Guardian #2 Name _____ Home # _____
Guardian #2 Address _____ City _____ Zip _____
Guardian #2 Employer _____
Work phone # _____ Cell # _____

Dental Insurance Co. _____ SubscriberName _____
Insurance Mailing Address _____
Insurance Co. Phone # _____ ID# _____ Group # _____

To assist us in keeping your child's medical history up to date, please answer the following:

Physician's Name _____ Phone # _____

1. Has your child seen his/her physician in the past year? Yes _____ No _____
If so, why? _____
2. Has your child's medical history changed in the past year? Yes _____ No _____
If so, how? _____
3. Is your child currently taking any medications (including Herbal or complimentary)?
Yes _____ No _____ If yes, what and why? _____
4. Has the patient received any injections in the past year? Yes _____ No _____
If so, what? _____
5. Any injury to head, neck or teeth in the past 12 months? Yes _____ No _____
If so, what? _____
6. Dental or medical related concerns or problems _____

In order to continue providing the best care for your children please offer your comments below:

1. Do you feel you and your child are treated well 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. Would you recommend our office to a friend or family member? Yes _____ No _____
If not, why? _____
5. In which manner(s) do you like to have appointments confirmed?
____ mail
____ email (provide address) _____
____ phone (which # is best) _____

I, being the guardian of the above patient, grant Indianapolis Pediatric Dentistry permission to provide my child with dental care and I will be responsible for the total cost of the dental care.

Date _____ Signed _____ Relationship to Patient _____