TLC PEDIATRIC DENTISTRY, LLC
266 SILAS DEANE HIGHWAY
WETHERSFIELD, CT 06109

Patient's Name: _____ DOB: _____ Age: _____

Address: _____

Home Phone: _____ Other Phone: _____

Name of person who holds insurance: _____ DOB: _____

Employer: _____ Work Phone: _____

***Email:** _____ ***Cell Phone:** _____

To assist us in keeping your medical history up-to-date, please answer the following questions:

Has your child seen a physician since his/her last visit (other than an annual physical)?
Yes ☐ No ☐ If yes, why? _____

Has there been a change in your child's general health since your last visit? Yes ☐ No ☐
If yes, what? _____

Is your child taking any medication at the present time? Yes ☐ No ☐
If yes, what and why? _____

Has your child had any serious injuries or illness since their last visit? Yes ☐ No ☐
If yes, what? _____ When? _____
Cause of injury? _____

Have there been areas in your child's mouth that cause pain or discomfort? Yes ☐ No ☐
If yes, where? _____

Are there any questions about your dental health that we can answer for you today?

_____

Comments:_____

_____

*Please use the back of this sheet if more room is needed for any part of this form.
****

Please Read and Circle:

If you have any questions regarding insurance coverage for the following, please contact your insurance company prior to appointment.

Fluoride is recommended after every professional cleaning. Do we have your permission to administer fluoride today? **YES / NO**

Cavity checking X-Rays are recommended once a year. If this patient is due for x-rays, do we have your permission to take x-rays today? **YES / NO**

Date: _____ Signature: _____

Print Name: _____ Relationship: _____

Form: CHS Re-care Form 6 mth