



**JIM CONGLETON, D.D.S., M.S. • ROBERT HARRISON, D.M.D., M.S.D.**  
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**CONTINUAL HEALTH STATUS REPORT**

Child's Name \_\_\_\_\_ Age \_\_\_\_\_  
 Parent's Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Address \_\_\_\_\_  
 Billing Address (if different than above) \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Father's Work Phone \_\_\_\_\_ Mother's Work Phone \_\_\_\_\_  
 Any New Dental Insurance \_\_\_\_\_ Address \_\_\_\_\_  
 Policy Holder's Name \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_  
 SS # \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Employer \_\_\_\_\_

**Email** \_\_\_\_\_

To assist us in keeping your child's medical history up to date, would you 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, how? \_\_\_\_\_
3. Is your child taking any medication at the present time?  YES  NO  
 If so, what and why? \_\_\_\_\_
4. Has your child received any injections within the last year?  YES  NO  
 If so, what? \_\_\_\_\_
5. Any injury to head or neck in last 6 months?  YES  NO  
 If so, what? (ex. front teeth) \_\_\_\_\_  
 Cause of injury (ex. car accident, bike, door, etc.) \_\_\_\_\_
6. Any dental problems developed or developing that you are aware of?  YES  NO
7. Other dental or medical related concerns or problems: \_\_\_\_\_

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

1. Do you feel you and your child are well treated 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. If your child has a very loose tooth, would you like us to remove it?  YES  NO

In an effort to reduce our billing costs so that we can keep our fees down, we require that your fees or estimated co-payments be made on the day of the appointment.

I will be paying today by:

- CASH     CHECK     CREDIT CARD     CARECREDIT     MEDICAID

Date \_\_\_\_\_ Signed \_\_\_\_\_

**AS OF AGE 15, MOST PATIENTS WILL BE REFERRED TO A GENERAL DENTIST**

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

**I hereby authorize Jim Congleton D.D.S., M.S. to furnish information to insurance carriers concerning my dependent's treatments and I hereby assign to the dentist all payments for his services rendered to my dependents. I understand that I am responsible for any amount not covered by insurance.**

**DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_**