RECARE FORM
All About Kids Pediatric Dentistry

Child's Name_____ Age: _____

Your Name_____ Parent/Legal Guardian: **Y / N**

(Your relationship to child; if not parent) _____

Address for the Child: _____

City_____State_____ Zip_____

*****We confirm all Appointments by Text message and/or Email*****

Please provide the best cell phone number and/or email below

Cell Number_____ Email_____

Additional Names and Numbers to contact _____

If you have updated your insurance since your last visit please give information to the Front Office Staff.

To keep your Child's Medical History up to date please answer the following questions.

1. Has your Child been to his or her Primary Care Doctor since your last visit? **YES OR NO**
   If yes, who? _____
2. Has your child had any changes in their Medical History since their last Visit? **YES OR NO**
   If yes, what? _____
3. Is your child taking any Medication? **YES OR NO**
   If yes, please list: _____
4. Has your child had any injuries to their face or neck since their last visit **YES OR NO**
   If yes, what? _____
5. Has your child developed any dental problems since their last visit? **YES OR NO**
   If yes, what? _____
6. Pharmacy Location and phone number: _____

PARENT SIGNATURE: _____ DATE: _____

DR SIGNATURE: _____