CONTINUAL HEALTH STATUS REPORT

PATIENT INFORMATION

Child's Full Name: _____Nickname: _____

DOB: _____ AGE: _____ Gender: _____

Guardian(1) Name: _____DOB: _____ SSN:_____

Guardian(2) Name: _____DOB: _____ SSN:_____

Address: _____City: _____State: _____Zip: _____

Home: (_____) -_____-_____ Cell: (_____) - _____-_____ E-Mail: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co. Name: _____Phone: (_____) _____-_____

Address: _____ City: _____State: _____Zip: _____

Group/Policy #: _____ I.D. #: _____

Subscriber's Name: _____ Gender: _____

DOB: _____ SSN: _____ Employer: _____

Secondary Insurance Co. Name: _____Phone: (_____) _____-_____

Address: _____ City: _____State: _____Zip: _____

Group/Policy #: _____ I.D. #: _____

Subscriber's Name: _____ Gender: _____

DOB: _____ SSN: _____ Employer: _____

MEDICAL HISTORY

Has your child been diagnosed and/or for any of the following… (check all that apply)

☐ Heart Murmur/Defect/Surgery
☐ Abnormal Bleeding/hemophilia
☐ Hepatitis
☐ Cancer/Tumor/Leukemia
☐ Cleft Lip/Palate
☐ Epilepsy/Seizures/Convulsions
☐ Cerebral Palsy
☐ Congenital Birth Defects
☐ Diabetes
☐ Liver Disease
☐ Blood Disorder
☐ AIDS/HIV/ARC
☐ Immunocompromised

☐ Autoimmune Disease
☐ Asthma/Reactive Airway
☐ Hearing Problems/Deaf
☐ Vision Problems
☐ Speech Problems
☐ Autism Spectrum
☐ ADD/ADHD
☐ Mental/Cognitive/Social Delay
☐ Kidney Problems
☐ Sickle Cell
☐ Stomach/GI Disorders
☐ Pregnant
☐ Use Tobacco Products

Allergies:
☐ Seasonal
☐ Drug: _____
☐ Food: _____
☐ Other: _____

Current Medications:
_____
_____

Other Condition (specify):
_____
_____
_____

Signature: _____ Date: _____