Treatment Recall Questionnaire

Patient's Name: _____ DOB: _____
Last First

In our efforts to maintain current records, we ask that you please review and respond to the following questions.

1. Please provide your current address: _____
Street

_____
City State Zip Code

2. Please provide a current contact telephone _____

3. Has there been any change in your MEDICAL HISTORY or medical physician? ☐ Yes ☐ No
If yes, please provide updated information:

_____

_____

4. Please provide emergency info of someone who does not live with Name: _____
Emergency contact telephone number: _____

5. Do you have any DENTAL INSURANCE? ☐ Yes ☐ No
If yes, is this the first time you've used your dental insurance? ☐ Yes ☐ No
If yes, please provide updated information:

_____

_____

6. Are you taking ANY NEW MEDICATION? ☐ Yes ☐ No
If yes, provide medications:

_____

_____

7. Have you had any DENTAL PROBLEMS since your last appointment? ☐ Yes ☐ No
If yes, please describe:

_____

_____

8. Parents: If you are not able to bring your child to their appointment, list the names of those you give permission to bring your child and to get treatment information.

_____

_____

9. When was your last dental appointment? _____

10 Email Address: _____

_____ 10/13/2025
Patient/Guardian Signature Date

Sealant Consent: I understand that the treatment of teeth through the use of sealants is a preventative intended to facilitate the inhibition of dental caries in the pits and fissures of the chewing surfaces of the teeth. I have been given the opportunity to ask questions and hereby consent to the application of sealants.

_____
Patient/Guardian Signature