Name of Patient:_____ DOB: _____

My child does best when:

_____

My child is afraid of:

_____

My child will feel more comfortable in your office if:

_____

In the past, my child had a successful dental or medical visit when:

_____

In the past, my child had a hard time at the dentist or doctor when:

_____

Name of Medication	What is it Taken For?	Times of Day Medicine is taken.	Dosage/Amount

Questions I have about oral healthcare for my child:
