



RECORD OF MEDICAL VISIT

DATE: _____

CHILD'S NAME: _____

DOCTOR'S NAME: _____

(circle one) **Medical** **Dental**

Accompanied by: _____

Own Parent TX Parent Family Specialist Other (relationship)

Dental: _____ Routine _____ Emergency
_____ Cleaning _____ X-Ray _____ Filling(s) # _____
_____ Repair _____ Injury _____ Extraction(s) # _____
_____ Braces – initial _____ Braces – adjust/follow-up
Other: _____
Treatment or Instructions: _____

Medication Prescribed: _____

Next Appointment: Date _____ Place _____

Medical at: _____ Physician's Office _____ Hospital _____ Other
Type: _____ Routine _____ Emergency _____ Follow-up
Reason: _____

Diagnosis: _____

Treatment: _____

Medication Prescribed: _____

Next Appointment: Date _____ Place _____