FENWAY HEALTH

Pediatric Dental/Optometry Form

DENTAL

	yes
Does your child have a dentist?	
Has your child been to the dentist in the last 6 months?	
Do you have a family history of decay?	
Is your child in any dental related pain?	
Does your child have a history of cavities?	
Are you interested in Fenway's Pediatric Dental Services?	
Would you like a representative from the Fenway's dental department to contact you regarding pediatric dental services available? **If yes, please provide your contact information below:** Name: _____ Phone: _____ Email: _____	

OPTOMETRY

	yes
Has your child ever had an eye exam?	
When was the last time your child had an eye examination?	
Do you have a family history of eye disease?	
Does your child show any eye issues such as squinting, eye turns, eye rubbing?	
Does your child have a history of wearing glasses, eye surgery or eye infections?	
Are you interested in Fenway's Optometry Services?	
Would you like a representative from the Fenway's optometry department to contact you regarding pediatric optometry services available? **If yes, please provide your contact information below:** Name: _____ Phone: _____ Email: _____	