Vivos Phone Intake Form | **KIDS**

Typically used for patients ages ≥11

Date: _____ **Your Name:** _____

Caller's Name: _____ **Relationship:** _____

Child's Name: _____ **Child's age:** _____

How did you hear about us/who referred you to the office? _____

What is happening with your child that prompted you to call?

Does the child have any of these symptoms?

Daytime Drowsiness		**Bedwetting**	
Chronic Allergies		**Dark Circles Under Eyes**	
ADD/ADHD		**Trouble concentrating/focusing**	
Chronic Ear Infections		**Anger/Aggression**	
Restless Sleep		**Snoring**	
Nightmares/Night Terrors		**Mouth Breathing**	
Crowded/Crooked Teeth		**Difficulty in School**	
Delayed Growth		**Irritability**	
Tonsils/Adenoids		**Problems with speech**	
Teeth Grinding			

Email Address: _____ **Phone Number:** _____

Date Scheduled for Screening: _____

Emailed parent information packet ☐ **Confirmed for Appointment?** ☐

Additional Notes

Cont. ->