CHILD'S NAME_____ **DATE:**_____

Home Phone #_____

Date of Birth_____

Current Address_____

Child lives with: (Please circle one) Mom & Dad Mom Dad Other _____

Mom's Name_____ Phone_____

Dad's Name_____ Phone_____

Person Financially Responsible for the Child_____

Insurance for Child_____ Policy Holder_____

Name of Medical Doctor_____ City/State_____

Emergency Contact_____ Phone_____

Relationship_____

List of current medications_____

CHILD'S ALLERGIES:

_____Anesthetic
_____Aspirin
_____Codeine
_____Ibuprofen
_____Iodine
_____Latex
_____Penicillin
_____Sulfa

Any other known allergies:_____

Does the child have any of the following medical conditions?

_____Asthma
_____Liver Disease
_____Heart Trouble
_____Stroke
_____Ulcers
_____High Cholesterol
_____High Blood Pressure
_____Kidney Disease
_____Cancer
_____Heart Murmur
_____Arthritis
_____Joint Replacement
_____Epilepsy/Seizures
_____Bleeding Problems
_____Diabetes
_____Sinus problems
_____Rheumatic Fever
_____Pregnant
_____Psychiatric Treatment

Any surgeries_____

MINOR/CHILD CONSENT

I, being the parent or guardian, do hereby request and authorize the dental staff to perform necessary dental services for my child, including x-rays, nitrous oxide (laughing gas), and administration of anesthesia and any services deemed advisable by the doctor, even if I am not present in the operatory during the dental treatment.

PERMISSION TO TREAT

Because your child is a minor it is necessary to have signed permission from a parent or guardian. The signature affixed below authorizes examination and treatment as necessary and the use of procedures the doctor may deem necessary during the performance of his services. Furthermore, the undersigned accepts responsibility of any financial obligations incurred for treatment of this patient. Photos and other dental records of the child may be used for teaching or instructional purposes.

DENTAL TREATMENT

I understand that during the treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary.

I have had full opportunity to read and consider the contents of the Consent Form and understand that by signing this consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

SIGNATURE_____ **DATE**_____