

MINOR / CHILD CONSENT

I, being the parent or guardian of _____ do hereby request
Name of minor/child
and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date _____

Signature of Insured/Guardian _____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____

Address _____

Date of last dental care _____ Date of last dental X-rays _____

Check (✓) if you have or had any of the following

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other (not mentioned) _____ |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever | |

MEDICATIONS

List medications you are currently taking:

Pharmacy Name _____

Phone _____

ALLERGIES

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Local Anesthetic | _____ |

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

Date _____ Signature _____