

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

Is Minor/Child under care of physician now? YES NO

Receiving any medication or drugs? YES NO

Ever been hospitalized? YES NO

Ever had surgery? YES NO

Is there excessive bleeding when cut? YES NO

Medications _____

Allergies _____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓).

<input type="checkbox"/> A.I.D.S./H.I.V.	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Measles	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

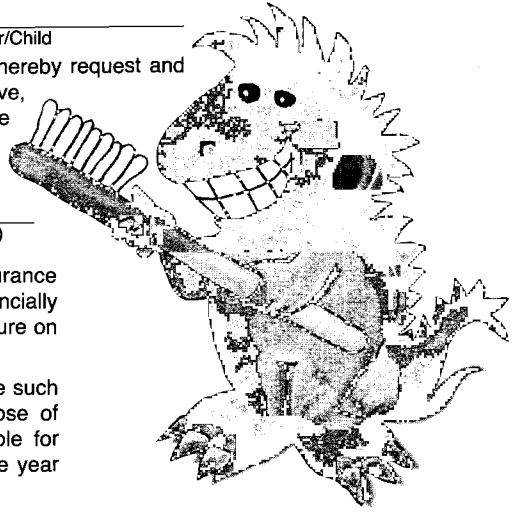
and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.



Signature of Parent, Guardian or Personal Representative

Please print name of Parent, Guardian or Personal Representative

Date

Relationship to Patient

AUTHORIZATION

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? Yes No

If yes, please describe _____

Is patient taking any new medications? Yes No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

UPDATE