Medical Health Update and Authorization for Treatment

Patient Name:____ **DOB:**________

Age _____ **Weight** ________

1. **Has there been any change in your child's health since his/her last visit?** ☐ **Yes** ☐ **No**
   (Ex.: hospitalized, infectious disease, allergies to medications or latex, other medical/dental conditions, etc.

2. **D**oes your child or anyone in the family have an allergy to latex**?** ☐ **Yes** ☐ **No**

3. **D**o we have permission to take bitewing or panoramic xrays today if, necessary? ☐ **Yes** ☐ **No**
   ☐ **Need more information**

4. **I**s your child taking any medications? ☐ Yes ☐ No If yes, what? ____________________________

5. **I**s your child taking a fluoride supplement? ☐ Yes ☐ No If yes, what? _________________________

6. **D**oes your child have a mouthguard for sports? ☐ Yes ☐ No ☐ Not applicable

7. What questions or concerns regarding your child's teeth and mouth can we answer for you today?

   ____

8. ***Please indicate any changes in your home address, email address, employment, or insurance information.***____

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CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I, the undersigned, authorize the performance of necessary treatment, medication and therapy that is indicated in connection with dental care for the above patient and authorize the doctors to choose and employ such techniques and assistance as deemed fit during dental treatment. Furthermore, I will be responsible for financial obligations incurred on this child for dental treatment. I extend my consent to release information and authorize my insurance company to pay benefits to this office.

______________________________________ ___________________________ __________________

Parent/Guardian Relationship to Patient Date