

**Patient** \_\_\_\_\_ Today's Date \_\_\_\_\_  
 First MI Last  
 Name child would like to be called \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Birthday \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Interested in email appointment confirmations? Yes or No Parent Email: \_\_\_\_\_  
 Emergency Contact (name & phone) \_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 street town state zip code

Name of Policy Holder \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
 Policy Holder's Employer \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is your child in good health? Date of last physical exam_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have there been any health changes since your child's last visit?_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child been hospitalized in the last 3 years? Please give reason & dates_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is your child allergic to anything?_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is your child currently taking any medications? Please give medication, dose and reason_____

Please elaborate on any items marked above: \_\_\_\_\_

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I give permission to the following people to bring my child to his/her future appointments:

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**Consent for Dental Treatment**

I request and authorize Dr. Amy C. Davidian, Dr. Martha Holland, and Dr. Mark Cummings to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by the dentist to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Amy C. Davidian, Dr. Martha Holland, and Dr. Mark Cummings will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Legal Guardian** \_\_\_YES\_\_\_NO If no, what is your relationship to patient? \_\_\_\_\_

**\*\*Just a friendly reminder-we value the privacy of our little patients and their families. We ask that you please avoid the use of all picture and recording devices within our office.\* \***