**DR. CHEN - HEALTH PLUS DENTAL CENTRE**

**Childs Consent for Services Authorization**

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I like to be called\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date (child): \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian #1) Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home#\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #\_\_\_\_\_\_\_\_\_\_\_Cell#\_\_\_\_\_\_\_\_\_\_

Birth date:\_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance Co. \_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_ Id#\_\_\_\_\_\_\_\_\_\_\_

#2) Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home# \_\_\_\_\_\_\_\_\_\_\_\_Work# \_\_\_\_\_\_\_\_\_\_\_\_Cell#\_\_\_\_\_\_\_\_\_\_

Birth date:\_\_\_\_/\_\_\_\_/\_\_\_\_\_

Insurance Co. \_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_ Id#\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Services**

I understand that I am personally responsible for payment of all services rendered for my child.

I certify that I have read and understand the above. I acknowledge that my questions, if any about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Childs Medical History **

Is the child taking any medications? Please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Pediatrician or Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child ever been diagnosed with any of the following conditions?**

Allergy to latex? **Y/N**

Allergy to drugs **Y/N** **If yes,** **please list:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergy to foods **Y/N If yes** **please list:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma **Y/N** **If yes, please list medications taken:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavior Problems **Y/N If Yes, please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chicken Pox **Y/N** **If Yes, when**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis/liver disease **Y/N**

Hearing Loss **Y/N**

Kidney disease **Y/N**

Cancer **Y/N**

Cerebral Palsy **Y/N**

Diabetes **Y/N If yes,** **please list medications taken:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Epilepsy/Seizures **Y/N**  **If** **yes,** **please list medications taken:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Disorders **Y/N If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Heart Disease **Y/N If Yes, please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Medical Conditions not listed (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications taken \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Childs Dental History **

Is this the child’s first visit? \_\_\_\_\_\_\_\_\_\_\_

Approximate date of last dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main concerns for your child’s visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever taken a major fall involving hitting the face or teeth? Y/N

If yes, was dental treatment required? Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child drink milk or juice continually during the infant stage? Y/N

How do you rate your child’s sugar intake (This includes milk, soft drinks, juice, candy, cereals, crackers, etc)

on a scale of 1- 10? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (1 being minimal)

Are you concerned about the development of your teeth? Y/N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have questions about orthodontic treatment? (Braces) Y/N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had any type of orthodontic treatment Y/N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child suck his/her thumb, fingers or use a pacifier? Y/N

Can your child breathe through his/her nose, or do you find they breathe through their mouth often? Y/N

Are you aware if your child snores or grinds their teeth? Y/N

How often does your child brush? A) Not at all

B) 1x daily

C) 2x daily

D) Couple times per week

E) Other

floss? A) Not at all

B) 1x daily

C) 2x daily

D) Couple times per week

E) Other

Does your child require help with this? Y/N