The Center for PEDIATRIC Dental Care & Orthodontics

209 Harvard Street, 2nd Floor • Brookline, Massachusetts 02446
T: (617) 731-KIDS (5437) • www.PediatricDentalCare.com

Patient Name: _____ D.O.B._____

Preferred Daytime Phone (please circle one) Home/Work /Cell: _____

E-mail: _____

Preferred Methods of Appointment Confirmation: (please circle one) E-Mail, Phone, Text

Has your child had:

Any hospitalizations, surgeries, or serious illness since their last dental cleaning? ❑ Yes ❑ No

Any accident involving the teeth or face? ❑ Yes ❑ No

Developed a latex allergy since they were last in? ❑ Yes ❑ No

If yes to any of the above, please explain: _____

Is your child taking medication routinely? ❑ Yes ❑ No

If yes, please list:

If Doctors recommend, may we have your permission to take dental X-rays today? ❑ Yes ❑ No

Do you have any questions or concerns about your child's dental care? ❑ Yes ❑ No

If yes, please explain: _____

Does your child participate in sports? ❑ Yes ❑ No

If yes, which sport(s): _____

If yes, do they wear a mouthguard? ❑ Yes ❑ No

Consent:

As your child is a minor it is necessary to obtain permission from a parent or guardian before today's treatment is performed. The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment. This consent shall remain in full force and in effect until cancelled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred by this child for dental treatment regardless of insurance coverage.
I fully understand this consent and have no further questions.

Parent/Guardian Signature: _____ Date: _____