Chapel Hill Pediatric Dentistry

Child's Name:_____________________________Age:__________
Parent's Name:____
Address (***IF NEW***):____________________________________
City:_____________________________Zip:_________________
Phone#:(**H**)________________________(**C**)___________________

1. Has your child seen his/her physician since your last visit? Yes No

2. Has your child's medical history changed since your last visit? Yes No

*If yes, what?*____

3. Is your child taking any medications at the present time? Yes No

*If yes, what?*____

4. Has your child developed any allergies? Yes No

*If yes, what?*____

5. Has your child received any injections within the last year? Yes No

*If yes, what?*____

6. Any injury to the head, neck, face or mouth in the last six months? Yes No

*If yes, what?*____

7. Any dental problems developed or developing that you are aware of? Yes No

8. Please list any other dental or medical related concerns or problems: ______________________________

9. **X-rays are often necessary for a thorough dental exam.**
Do we have your permission to take diagnostic x-rays if needed? Yes No

If you are 18 years or older, please list the person(s) you give us permission to discuss your PHI (Personal Health Information)?

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Do we have your permission to mail you a postcard reminding you to schedule your child's next recall appointment? Yes No

What number may we leave a message regarding your child's appointment and/or account information?_______________________________________

Consent for treatment: Signature:__________________________________

Date:_____________________________________

Please provide us with your email address:____