Medical Update & Consent to Treat

Required every six months by State Regulations & Insurance

Patient's Name _____ DOB_____ Age _____

Address _____

Cell Phone_____

E-Mail _____

***If* the patient has state supplemental secondary insurance, please list:**
Carrier Name_____

Group#_____ID#_____

Date of last medical examination _____
Health is: Excellent ____ Good ____ Fair ____ Poor ____

Since last dental visit, all questions pertain to the patient:

Have there been any diagnosed behavior issues?_____
New illnesses?_____
Diagnosed allergies (including latex sensitivity)_____
Medications now being taken _____
New hospitalization for child: Date & reason _____
Are you or do you suspect you are pregnant? _____
Other information you feel we should know _____
Oral habits_____
Sports played: _____
Does the patient use a mouthguard? Yes_____ No_____
Any dental trauma? _____
Brushing per day teeth: 1 2 3 4
Brushing per day tongue: 1 2 3 4
Flossing per day: 1 2 3 4
Fluoride toothpaste: Yes _____ No _____
Fluoride supplement: Yes _____ No _____
Toothbrush: Hard_____ Medium _____Soft _____
Does patient have artificial joints or dental implants? Yes_____ No_____
Is patient receiving orthodontic care? Yes _____ No _____
Name of Orthodontist _____

Today we will complete a routine oral exam, cleaning, and fluoride treatment. Bitewings are taken once per year. Complimentary orthodontic evaluation is completed during the exam. I give my consent to treat the above-named patient.

Parent Signature Required _____ Date _____

Dr. Signature_____04/12