Name:_____
(FIRST) (M) (LAST)

Medical History:

Yes	No		Yes	No		Yes	No	
□	□	Anemia	□	□	Diabetes	□	□	Mental/Emotional Problems
□	□	Asthma/Lung Problems	□	□	Ear Infections	□	□	Pregnant
□	□	Birth Defects	□	□	Fainting Spells	□	□	Premature/Low Birth Weight
□	□	Bleeding Problems	□	□	Hearing Loss/Impairment	□	□	Psychiatric Problems
□	□	Blood Pressure Problems	□	□	Herpes	□	□	Immune Disorders/HIV
□	□	Cerebral Palsy	□	□	Kidney Disease	□	□	Rheumatic Fever
□	□	Cleft Lip/Palate	□	□	Liver Disease/Hepatitis	□	□	Seizures/Epilepsy
□	□	Delayed Development	□	□	Malignancy, Cancer	□	□	Sickle Cell Anemia/Trait
□	□	Heart Problems/Murmurs	□	□	Latex Allergy/Sensitivity	□	□	Speech Problems

□ Other _____

Pediatrician's Name: _____Last Visit: _____Phone Number:_____
Is your child allergic or had any adverse reaction to a medication? □ Yes □ No
If yes, please explain: _____
Is your child taking any medications? □ Yes □ No
If yes, please list medication, dosage, and reason for medication:_____
Has your child ever had an operation, been hospitalized, or treated in an emergency room? □ Yes □ No
If yes, please explain why and when: _____

Consent for Treatment

(State law requires us to obtain your consent for contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it.)

I understand that the information that I have given is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status. Your child is a minor; therefore it is necessary that a signed permission be obtained from a parent of guardian before necessary dental services can be started. I authorize, request, and permit to Dr. Kiening and any employees/staff under her direct supervision to provide any dental/medical treatment necessary in connection with my child. This includes the use of any necessary or advisable local anesthesia, radiographs (x -rays) or diagnostic aids.

In general terms dental treatment may include:

A. Cleaning of the teeth and application of topical fluoride.
B. Application of plastic "sealants" to the groves of teeth.
C. Treatment of diseased or injured teeth with dental restorations (fillings or crowns).
D. Removal (extractions) of one or more teeth.
E. Treatment of malposed "crooked" teeth and/or oral development of growth abnormalities.
F. Use of sedative nitrous oxide/oxygen if needed to assist in a more pleasant dental treatment.
G. Other_____

Good results are expected, however I am advised of the possibility of unanticipated complications. Therefore there can be no guarantee expressed or implied either as to the result of the treatment or as a cure. Although their occurrence is extremely rare, there is some risk of infection, swelling, numbness, bleeding, discoloration, aspiration of foreign objects, vomiting, nausea, and allergic reactions. I further understand and accept that complications may require hospitalization and may even result in death. I hereby state that I have read and understand this consent, and that all questions have been answered in a satisfactory manner. I understand that this consent will remain in effect until such time that I choose to terminate it.

Signature_____ Relationship to child_____ Date_____