Child Dental History

Child's name: _____ Date of Birth: _____

Has your child ever been to the dentist? Yes ____ No ___

If so, what was the name of the last dentist and the date of last visit with them?

_____

Has your child experienced any unfavorable reaction from previous dental care? Yes ___ No ___

If so, please explain _____

Is there any additional information we should know that will help us provide a positive dental experience for your child? _____

Has your child had any of the following	Yes	No	Comments
Pain or sensitivity in the teeth			
Swelling of the mouth and face			
Injury to the face or teeth			
Cavities			
Gum infections			
Jaw sounds			
Orthodontics			

Consent for Dental Treatment

I, being the parent or legal guardian of _____, authorize, request and permit Dr. Richards and any employees under his supervision, to perform any and all manner of dental treatment that may be indicated in connection with my child and to do whatever procedures that the judgement of Dr. Richards may indicate during treatment. I further authorize the administration of such aesthetics and the taking of x-rays as may be deemed advisable by Dr. Richards. The risks and nature of treatment have and shall continue to be explained to me as treatment progresses and no warranty or guarantee has been made as to the result or cure. I assume responsibility for any and all charges incurred on behalf of my child for dental treatment.

Signature_____ Relationship _____

Date _____