just for kids dentistry

MEDICAL / DENTAL HISTORY UPDATE

(FOR THE SAFETY OF OUR PATIENTS, WE REQUIRE A MEDICAL UPDATE EVERY 6 MONTHS)

**CHILDS/CHIDRENS NAME(s)**

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DO YOU HAVE ANY CONCERNS / QUESTIONS ABOUT YOUR CHILD’S DENTAL HEALTH THAT WE CAN ANSWER TODAY?

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ANY ALLERGIES?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN ORDER TO KEEP YOUR CHILD’S RECORD UP TO DATE AND ACCURATE, PLEASE CHECK OFF ANY CHANGES AND NOTE BELOW TO EXPLAIN:

\_\_\_ PARENTS MARITAL \_\_\_DENTAL INSURANCE \_\_\_MEDICAL CONDITION

STATUS PARENTS NAME

\_\_\_FINANCIAL \_\_\_HOME ADDRESS \_\_\_PHONE NUMBERS / E-MAIL ADDRESS

RESPONSIBILITY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In an effort to improve communications with our patients, **just for kids dentistry** will e-mail and / or text appointment reminders. If you are interested in being part of this service, please enter your information below. Please be aware that this e-mail address may also be used to email your personal information (ie, Receipts, Invoices, Letters) relating to your Child’s dental care, your information is only used for communications with you and other dental professionals. We do NOT share or sell personal information.

E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please Print Clearly) (Be aware of your phone service texting fee)

**Informed consent for parents / guardians accompanying the child**

I hereby authorize the dentists and staff at **just for kids dentistry** to perform diagnostic aids including an examination, x-rays, photography’s, models, cleaning and fluoride treatment, when necessary, as the standard of care properly diagnose and record any and all dental conditions. (Please cross out any treatment that you do not want performed.) I authorize my insurance company to pay **just for kids dentistry** all insurance benefits. Otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance. I also understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility **just for kids dentistry**. This consent is to remain in effect from the date indicated until cancelled in writing.

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PRINT YOUR **LEGAL** NAME SIGNATURE DATE

RELATIONSHIP TO CHILD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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