

Please Answer the Following Questions

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

If yes, please explain: _____

Is your child taking any medication at this time? **Yes** **No**

If yes, please list: _____

Has your child received any injections in the last six months? **Yes** **No**

If yes, please explain: _____

Has your child had any injury to the head or neck in the last six months? **Yes** **No**

If yes, please explain the type of injury and cause: _____

Have any dental problems developed since your child's last visit? **Yes** **No**

If yes, please explain: _____

Are there any medical or dental problems you wish to discuss with the doctor? **Yes** **No**

If yes, please explain: _____

What would you suggest to improve our service in the future? _____

Please list any dental procedures that you do not wish to be performed for your child: _____

By signing below you agree to the following:

I do not hold Dr. James Hutton and Dr. Heather Owens responsible for any detrimental effects that may result from these procedures not being performed.

I understand that certain dental procedures are not covered by my insurance. I want the procedures rendered that represent the standard of care of the American Academy of Pediatric Dentistry and the American Dental Association. I agree to pay for any expenses not covered by my insurance. I understand that should there be a procedure that I do not wish performed on my child that I must notify the office prior to my child's visit.

Signature of Parent or Legal Guardian

Date Signed