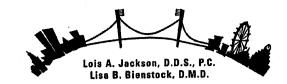
## AUTHORIZATION FOR A DESIGNATED ADULT TO CONSENT FOR AND ACCOMPANY MINOR PATIENT

| I,, the father/mother/legal guardian of (Name of parent or guardian) |
|--|
| (Name of parent of guardian)   |
| authorize to   |
| (Name of child) (Adult 18 years or older who will accompany child)   |
| accompany my child (or legal ward) for whom I am empowered to        |
| consent; and to give consent for any necessary dental procedures,    |
| including dental x-rays if indicated. This authorization will remain |
| in effect until such time as I give notice of its termination.       |
|  |
| ·  |
| (Signature of parent or legal guardian) (Date)                       |



## PEDIATRIC DENTISTRY

## CONTINUAL HEALTH STATUS REPORT

| Child's Name  |                           |                 |
|---|---------------------------|-----------------|
| Parent's Name   |                           |                 |
| Address(City)   |                           | (Zip            |
| Cell phone Home phone   | <u></u>                   | ( <b>c</b> .ip. |
| Mother's or first parent current employer   | Work Phone                |                 |
| E-mail  |                           |                 |
| Father's or second parent current employer  | Work Phone                |                 |
| E-mail  |                           |                 |
| To assist us in keeping your child's medical history up to date, would y                      | ou please answer the foll | owing           |
| questions:  |                           |                 |
| Has your child seen his/her physician since your last visit?     If so why?                   | YESNO                     |                 |
| Has your child's medical history changed since your last visit?     If so why? Any allergles? | YES NO                    |                 |
| Is your child taking any medication at the present time?  If so what and why?                 | YES NO                    |                 |
| Has your child received any injections within the last year?     If so what?                  | YES NO                    |                 |
| 5. Any injury to head or neck in last 6 months?  If so what? (ex. front teeth)                | YES NO                    | <br>7           |
| Cause of injury (ex. car accident, bike, door, etc.)  |                           |                 |
| 6. Any dental problems developed or developing that you are aware o                           | 77 YES NO                 | . Y.,           |
| 7. Other dental or medical related concerns or problems If so what?                           | YES NO                    |                 |
| In order to continue to provide the best possible care of your child worbelow:                | uld you please offer your | comments        |
| Do you feel you and your child are well-treated in our office?  If not, why not?              | YES NO                    |                 |
| 2. What do you like most about your treatment in our office?                                  |                           |                 |
|   |                           |                 |