**Consent for Treatment of a Minor**

In providing dental care, we will treat your child as we would our own. Dentistry is an important health service for your child, and it is our goal to provide him/her with a satisfying experience in our office. Please read this form carefully. Should you have any questions, or staff will be happy to help you.

1. I hereby authorize and direct Dr. Capezio, associates and the staff of Capezio Loiben Pediatric Dentistry to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2. I understand certain parts of the treatment may be performed by certified paraprofessionals (dental hygienists and assistants) other than the dentist.
3. I understand x-rays, photographs, models of the mouth and/or any other diagnostic aid used for an accurate diagnosis and treatment planning are the property of the doctor but copies are available upon request, some for a fee.
4. In general terms, the dental procedure(s) can include but not be limited to:
    a. Comprehensive oral examination, radiographs, cleaning of the teeth and the application of topical fluoride.
    b. Application of sealants to the grooves of the teeth.
    c. Treatment of diseased or injured teeth with dental restorations, stainless steel or composite crowns, and/or root canal treatment.
    d. Oral surgery, extraction of one or more teeth, excision of hyperplastic and/or pericoronal tissue, frenectomy, exposure of unerupted tooth.
    e. Placement of space maintainers and/or replacement of missing teeth with dental prosthesis.
    f. Treatment of diseased or injured oral tissues secondary to traumatic injuries and/or accidents and/or infection.
    g. Treatment of habits, malposed crooked) teeth, orthodontia and/or oral, dental developmental or growth abnormalities.
5. I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement.
6. I realize that guarantees of results or absolute satisfaction are not possible in dental health service.
7. I have answered all the questions about my or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all conditions, including allergies. I will not hold Dr. Capezio or any of his staff responsible for any errors or omissions I may have made. I also understand if I or my dependent ever have any changes in health status or any changes in medications, I will inform the doctor at the next appointment.
8. I authorize Capezio Loiben Pediatric Dentistry to forward a review of findings and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care provider for his/her records, as well as any third parties such as insurance companies who may request information.

I hereby acknowledge that I have read and understand this consent & the meaning of its contents. All questions have been answered in a satisfactory manner & I believe I have sufficient information to give informed consent for treatment. I further understand that this consent shall remain in effect until terminated by me.

_____ _____

Patient's Name Date

_____ _____

Parent or Guardian Relationship to Patient

**Capezio Loiben Pediatric Dentistry**

**MEDICAL AND DENTAL HEALTH HISTORY**

DATE: _____

Patient Name _____ Date of Birth _____Weight _____

Name of Contact (other than parents) for Emergencies _____

Contact's Relationship to Patient _____ Phone # _____

Pediatrician's Name _____

_____ _____
Address (or city) Phone

1. Is your child under a physician's care at this time? _____

   If Yes, why? _____

2. Is your child presently taking any medication? _____

   If Yes, name of medication _____ Dosage _____

3. Has your child had an allergic reaction to any medication or an adverse drug reaction? __

   If Yes, what medication(s)? _____ Describe reaction: _____

   _____

4. Has a physician ever informed you that your child requires antibiotics before dental treatment? _____

5. Has your child ever been hospitalized? _____
   If Yes, describe the circumstances (why, when, where?)

   _____

   _____

6. Please place an "X" to indicate if your child has a history of the following:

| | | |
|---|---|---|
| ___ Anemia | ___ Bleeding Problems | ___ Cerebral Palsy |
| ___ Arthritis | ___ Speech Problems | ___ Muscular Dystrophy |
| ___ Asthma | ___ Breathing Problems | ___ Chicken Pox |
| ___ Autism | ___ Circulatory Problems | ___ Physical Disabilities |
| ___ Diabetes | ___ Hearing Problems | ___ Learning Disabilities |
| ___ Epilepsy | ___ Heart Problems | ___ Mental Retardation |
| ___ Hepatitis | ___ Heart Murmur | ___ Nutritional Problems |
| ___ HIV Positive | ___ Kidney Problems | ___ Metabolism Problems |
| ___ Malignancies | ___ Liver Problems | ___ Rheumatic Fever |
| ___ Measles | ___ Intestinal Problems | ___ Scarlet Fever |
| ___ Mumps | ___ Nervous Problems | ___ Tonsillitis |
| ___ Seizures | ___ Glandular Problems | ___ Psychiatric Problems |

CHECK HERE IF YOUR CHILD HAS NO HISTORY OF ANY OF THE ABOVE: ___ NONE

7. Are there any other pertinent facts in your child's history? _____

_____

8. Reason for today's visit _____

9. Is this your child's first visit to the dentist? _____

10. Does your child have any particular fears or apprehensions? _____

_____

11. Has your child ever had a negative dental or medical experience? Describe. _____

_____

12. What could Dr. Capezio do differently than previous doctors to satisfy you? _____

_____

13. How were you referred to Drs. Capezio and Loiben?

_____

We like to acknowledge our patients for referring others. If you prefer not to have your name mentioned please circle. NO

***I have provided all pertinent facts regarding my child's medical and dental history.***

Signature of Parent or Legal Guardian: _____ Date: _____

**CAPEZIO LOIBEN PEDIATRIC DENTISTRY**

**Patient/Parent Information**

Mother's Name _____ SS# _____ Birthdate _____

Father's Name _____ SS# _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Cell Phone (Mother) _____ Cell Phone (Father) _____

Home Phone _____ E-Mail _____

Bus. Phone (Mother) _____ Occupation _____

Company Name _____

Bus. Phone (Father) _____ Occupation _____

Company Name _____

**Other Parent If At Different Address**

Name _____ Cell Phone # _____

Address _____E-Mail _____

City _____ State _____ Zip _____

| **Patient Full Name(s)** | **M/F** | **Birthdate** | **Nickname?** |
|---|---|---|---|
| 1) _____ | /____/ | _____ | _____ |
| 2) _____ | /____/ | _____ | _____ |
| 3) _____ | /____/ | _____ | _____ |
| 4) _____ | /____/ | _____ | _____ |

***I understand and acknowledge that I am financially responsible for all charges for professional services rendered to the family member(s) listed above. I am aware that I may be charged a fee for missed appointments or cancellations with less than 48 hours notice.***

Signature: _____ Date: _____

***I will be paying for today's professional services by:*** **[ ] Cash [ ] Check [ ] Visa**
**[ ] American Express [ ] MasterCard [ ] Discover**