To: Pediatric Dentistry of Reading

From: _____ Date: _____

Patient Name: _____ DOB: _____

Date of Appointment: _____

Name of Person Accompanying Patient: _____

Relationship to Patient: _____

In Case of Emergency during this visit,

Parent's contact # at time of appointment: _____

I, _____, will be unable to accompany my child to his/her upcoming dental appointment. I give my permission to Pediatric Dentistry of Reading to treat him/her as needed and to take any necessary x-rays.

Medical History

(Please check all that apply)

_____ There are **NO CHANGES** in my child's medical history since his/her last visit

_____ There are the **FOLLOWING CHANGES** in my child's medical history since his/her last visit

_____

_____

_____ My child is currently taking **NO MEDICATIONS**

_____ My child is currently taking the **FOLLOWING MEDICATION(S)**

_____

_____

_____ Permission for Fluoride treatment

_____ Permission for X-Rays

_____ Permission to discuss treatment with person accompanying child

_____ Permission for Nitrous if needed

X _____

Signature of Parent or Legal Guardian

Please fax to 484-334-2311

Prior to your child's next appointment

Thank You