Busciglio Smiles
Orthodontics & Pediatric Dentistry
Simply Smile & Stand Out

Medical History Update

Patients Name_____ Date of Birth_____

IMPORTANT NOTICE: WE REQUIRE A PARENT OR LEGAL GUARDIAN BE PRESENT AT ALL APPOINTMENTS.

PLEASE NOTIFY THE FRONT DESK IF YOU ARE NOT THE PARENT OR LEGAL GUARDIAN OF THE PATIENT.

Has your child's medical history changed since his/her last visit to this office? ❑ Yes ❑ No

If YES, please explain:_____

Is your child currently taking any medications? ❑ Yes ❑ No

If YES, please explain:_____

Does your child have any heart conditions? ❑ Yes ❑ No

If YES, what conditions?_____

Does your child require antibiotic prophylaxis or premedication before any dental treatment? ❑ Yes ❑ No

If YES, please explain:_____

Does your child have any allergies to food, latex, or any medications? ❑ Yes ❑ No

If YES, please explain: _____

Do you have any concerns you would like us to pay close attention to at today's visit? ❑ Yes ❑ No

If YES, please explain:_____

Were there any *changes* in your **address**, **phone number**, or **dental insurance**? ❑ Yes ❑ No

*If you have new dental insurance that was not given to us **prior** to todays appointment time, please present it to the front desk and be aware that there will be a wait as we have to verify the new insurance policy.*

If YES, please add them: _____

_____

If you are the parent and ***do not*** currently receive our text or email reminders and would like to, please add them below (It can only go to one email/phone number):

_____

Consent for Dental Treatment

I, undersigned parent/legal guardian, authorize Busciglio Smiles staff to examine this child, clean his/her teeth, perform necessary dental treatment, administer local anesthetics, administer medications, apply topical fluoride, obtain study models and other records necessary for an accurate diagnosis for my child. I further request and authorize the taking of dental radiographs (x-rays) as may be considered necessary by the doctor and staff to diagnose and/ or treat my child's dental condition. I will allow photographs to be taken of my child and/ or my child's teeth for diagnostic or educational purposes. I understand that dental treatment for my children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. We will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, using variable voice tone, mouth props, nitrous oxide (laughing gas), or protective stabilization when necessary to promote cooperative behavior and a positive experience and to protect my child from potential injury. I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my child's medical status. I understand that I am responsible for the cost of these dental services at the time of the visit.

_____ _____ _____

Signature of Parent or Legal Guardian **Relationship to Child** **Date**