

A. JAY CITRIN, D.D.S.
CONSENT FOR TREATMENT OF A MINOR (CHILD) PATIENT
(This will be kept confidential. Please print.)

Patient's name _____ Patient's date of birth _____

Mother's name _____ Mother's date of birth _____

Mother's address _____ City _____ State ____ Zip _____

Mother's phone # _____ cell # _____ Mother's SSN _____

Mother's employer _____ Work phone # _____

Father's name _____ Father's date of birth _____

Father's address _____ City _____ State ____ Zip _____

Father's phone # _____ cell # _____ Father's SSN _____

Father's employer _____ Work phone # _____

Does patient live with mother, father or both? _____ Who is responsible for this acct? _____

Name of nearest relative NOT living with you _____ phone # _____

Relative's address _____ City _____ State ____ Zip _____

Does patient have dental insurance? Yes No

If yes, who is the subscriber? _____

Name of Insurance Company _____ Insurance Co. phone # _____

Subscriber's ID # _____ Group # (if any) _____

Insurance Company address _____ City _____ State ____ Zip _____

CONSENT FOR INSURANCE PAYMENT: I hereby authorize payment to A. Jay Citrin, D.D.S. for insurance benefits, if any, otherwise payable to me for services but not to exceed the benefits provided for covered services.

SIGNATURE _____ Date _____

Reason for patient's visit _____ Date of last dental exam _____

Does patient have any drug allergies? Yes No If yes, what? _____

Is the patient taking any medications? Yes No If yes, what? _____

Patient's Medical Physician _____ Physician's phone # _____

Medical physician's address _____ City _____ State ____ Zip _____

Has the patient ever had: Heart Trouble Bleeding Problems Rheumatic Fever Heart Murmur

(Check all that apply) Hepatitis Jaundice Liver Disease Fainting Seizures Asthma

Does the patient have or has he or she been exposed to AIDS or HIV virus? Yes No

Are there any health conditions the patient has that we should be aware of? Yes No

If yes, please explain _____

CONSENT FOR TREATMENT: I hereby grant authority to the dentist in charge of the care of the patient whose name appears on this form to administer treatment deemed necessary or advisable in the diagnosis and treatment of this patient.

SIGNATURE _____ Relationship to patient _____ Date _____