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 _____