Wright Smiles pediatric dentistry

Cleaning Appointment Consent

Patient's Temp:

Parent's Temp:

Date: _____ Child's Name: _____

Your Name: _____ Relationship to Child: _____

Phone Number: _____ Email: _____

******Please inform staff if patient has had any x-rays at any other dental office******

IF DUE, do we have your consent to do the following:		
FLUORIDE	YES	NO
BITEWING / INTRAORAL X-RAYS	YES	NO
PANORAMIC XRAY	YES	NO

****MOST insurance companies cover Fluoride and Bitewing x-rays ONCE a year. Review your dental benefits for further details****

Is your child in braces?	YES	NO
Any changes to your insurance?	YES	NO
If YES, please list:		

Any CHANGES in child's health history since their last visit with us? YES or NO

If YES, please list: _____

Parent Signature: _____

Additional Comments: _____