TO: Pediatric Dentistry of Mullica Hill

From: _____ Date:_____

Patient's Name:_____ Age_____

Date of Appointment:_____

Name of Person Accompanying Patient _____
Relationship _____

In case of emergency,
*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 Mullica Hill to treat him/her as needed, take any necessary x-rays and discuss treatment with the Person accompanying my child."

Medical History: (please check those that apply)

_____There are **NO changes** in my child's medical history since their last visit.

_____There are the **following changes** since my child's last visit:
_____
_____

_____My child is currently taking **NO medications**.
_____My child is **currently taking the following** medication(s):
_____
_____

_____Permission for Fluoride

_____Permission for X-Rays

_____Permission for Nitrous Oxide

_____
Signature of parent or legal guardian

Please fax to 856-842-5220
Prior to your child's next appointment.
Thank You!