Harbour City
DENTAL HYGIENE

Warm friendly service for the whole family

MEDICAL HISTORY AND CONSENT

SERVICES AVAILABLE

I would like my child to receive the following treatment

Screening _____ Yes _____ No

Fluoride treatment _____ Yes _____ No

PATIENT INFORMATION

Name: _____ BC Care Card # _____

Address: _____ Date of last x-rays _____

_____ Date of Birth _____/_____/_____

_____ D M Y

PARENT / GUARDIAN

Name: _____ Phone # _____

Email: _____ Cell# _____

Address:(**If different from above**) _____

_____

MEDICAL INFORMATION

Please list any allergies: _____

Please list any medications: _____

Please list any medical conditions: _____

_____

GENERAL RELEASE: I the undersigned, understand that the information contained in the medical and dental history is important to my or my dependants. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I authorize this dental hygiene office to perform diagnostic procedures as may be required to determine necessary treatment. I consent to the above dental treatment and that I or my dependant has had a dental exam in the last 365 days .

SIGNATURE _____

PARENT / GUARDIAN Date Print Name

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