Dr. Elizabeth Kitsos
Pediatric Dentistry

INSURANCE

Father's/Guardian Name	Mother's/Guardian Name
Address (if different from patients)	Address (if different from patients)
Home phone _____ Work Phone _____	Home phone _____ Work Phone _____
Employer	Employer
Soc Sec # _____ Birthdate _____	Soc Sec # _____ Birthdate _____
Do you have dental insurance for minor Child? Yes ☐ No ☐	Do you have dental insurance for minor Child? Yes ☐ No ☐
Plan Name	Plan Name
Plan Phone Number	Plan Phone Number
Plan Address	Plan Address
Plan Group Number	Plan Group Number
Plan Policy Number	Plan Policy Number

CONSENT

1. The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor for a thorough diagnosis of the patient' dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate mediation and therapy indicated for such treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize, and consent hat the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. To the best of my knowledge, the above information is complete and accurate. I understand that even though I may have some type of dental insurance coverage, I am responsible for payment services rendered. I authorize release of any information to me insurance company related to my dental claims.

Parent/Guardian Signature _____   Date_____

Dentist Signature _____   Date_____

DENTISTS COMMENTS

Medical consultation recommended? No ☐   Yes ☐   Date Required _____
Purpose of consultation? _____

SEMIANNUAL REVIEW OF MEDICAL-DENTAL HISTORY: If history remains essentially unchanged, sign below

Parent/Guardian Signature _____   Date_____
Dentist Signature _____   Date_____

Parent/Guardian Signature _____   Date_____
Dentist Signature _____   Date_____

Parent/Guardian Signature _____   Date_____
Dentist Signature _____   Date_____