Le Dentistry
FAMILY DENTAL CARE

NEW PATIENT FORM (MINOR)

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
Referral source:		School:	
Referred by:		Special needs:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Parent/Guardian (Primary Contact)

Full Name:	
Relation:	
DOB:	
Mobile phone:	
Email:	
Has legal custody:	
Employer:	

Parent/Guardian (Secondary)

Full Name:	

Parent's signature: Date:

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CONSENT FOR DENTAL TREATMENT

As the parent and/or legal guardian of the patient, I do hereby request and authorize Bridgeview Dental and their staffs to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. We will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Bridgeview Dental of any changes in my child's medical status.

Parent's signature: Date:

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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Bridgeview Dental offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Bridgeview Dental will use reasonable means to protect the security and confidentiality of email information sent and received. However, Bridgeview Dental cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Bridgeview Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Bridgeview Dental.

Parent's signature: Date:

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TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Bridgeview Dental offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Bridgeview Dental will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Bridgeview Dental cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Bridgeview Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Bridgeview Dental.

Parent's signature: Date: