Children's Dental Health Center P.C.

Derek Zurn D.D.S., M.S. & Associates
Pediatric Dentistry and Orthodontics
966C Park Street, Stoughton, MA 02072
781.341.0030

Date: _____

Parent/Guardian Name: _____

Patient Name & DOB: _____

Responsible person for today's appointment and relationship:
_____

The above person has permission to go over health history, consent for treatment (including x-rays, fluoride treatment, or other services scheduled for the day), and to make any payments due on the date of service.

I can be reached at _____ during the appointment should any questions or issues arise, or significant changes made to the planned treatment.

Medical Updates

DATE CHANGES: YES____ NO_____

_____ _____

_____

_____

Current Medications

_____

_____

_____

_____

Any recent hospitalizations or Surgeries: _____

Routine immunizations up to date: YES_____NO_____

_____

Signature & Date