Dr. Henry D. Duncan, DDS, PA
814 Sloop Avenue
Kannapolis, NC 28083

Authorization To Consent to Dental Care for Minor

I, _____ , am the custodial parent having legal custody of _____ , a minor child, age _____ , born _____ , 20 _____. I authorize Dr. Henry D. Duncan, to do any acts which may be necessary or proper to provide for the dental care of the minor child, including, but not limited to, administration of anesthesia, X-ray examination, performance of dental surgery and other dental procedures.

This consent shall be effective from the date it is executed until the date I terminate it in writing. By signing here, I indicate that (i) I have the understanding and capacity to recognize the importance of, to communicate, and to assign the dental treatment decisions covered by this document, (ii) I am fully informed as to the contents of the document, and (iii) I understand the full scope and importance of this grant of powers to the agent named herein.

_____ _____ _____

Signature Date Staff

MEDICAL HISTORY

NAME: _____ **Date of Birth:** _____

Date: _____
Update: _____
Update: _____
Update: _____

Have you ever had:

Diabetes	Yes	No
Epilepsy	Yes	No
Hepatitis	Yes	No
HIV/AIDS	Yes	No
Hemophilia	Yes	No
Cancer	Yes	No
Ulcer	Yes	No
High blood pressure	Yes	No
Radiation treatment	Yes	No
Tuberculosis	Yes	No

Sickle cell anemia	Yes	No
Prosthetic heart valve	Yes	No
History of endocarditis	Yes	No
Organic heart murmur	Yes	No
Mitral valve prolapse	Yes	No
Pacemaker	Yes	No

_____
_____
_____

Are you allergic or had a reaction to:

Penicillin	Yes	No
Aspirin	Yes	No
Codeine	Yes	No
Erythromycin	Yes	No
Dental numbing/anesthetic	Yes	No

Other drugs:	Yes	No

What? _____

_____

Has a medical doctor advised taking antibiotics prior to dental treatment due to concerns for your heart or replacement joint? . . . . . Yes No

Are you taking aspirin every day? . . . . . Yes No

Are you taking any drugs or medications?

What? _____ for what? _____

What? _____ for what? _____

What? _____ for what? _____

What? _____ for what? _____

Do you have any disease, condition or problem not listed above that I should know about? Yes No

If so, explain _____

Women:

Are you pregnant or nursing? . . . . . Yes No

Are you taking birth control pills? . . . . . Yes No

Medical Doctor's Name _____ **City** _____ **Phone #** _____

DENTAL HISTORY

Why are you seeking dental care at this time? _____

Are you having dental pain? _____

Have you had a dental examination in the last 2 years? _____ Were x-rays taken during that examination? _____

Have you had any serious trouble with any previous dental treatment? _____

Do you use tobacco products? Yes No What? _____

_____ Date _____

Signature of person completing medical history