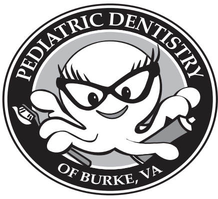

David M. Treff, DDS
5284 Lyngate Court •Burke, VA, 22015
703-712-8077 Office • 703-562-0812 Fax
www.PediatricDentistryofBurke.com

Child's Full Name: ____________________________________ Nickname: ___________________ Sex: _M_ F

Date of Birth: ____/____/_____ Age: _____ Home Phone (___)____________

Address: ________________________ City: ________________State___________ Zip Code:____________

Grade: __________ School: ____

Name(s) and ages of other children in family: ____

Please list the child's hobbies / interests: ____

Whom may we thank for referring you? ____

Who is accompanying the child today? ________________________________ Relation: ___________________

Who has legal custody of this child? ____

Parent/Legal Guardian Information: (please circle) Mother/Father Step Mother/Father Guardian

Parent's Marital Status: (Please Circle) Married Divorced Separated Widowed Single

Name: ____ Date of Birth: __________________________

Social Security #: _______________________ Email: ____

Address: ____

Cell / Other Phone _________________________ Work Phone #: __________________________
Employer: ____
Medical Insurance Plan Name:________________________ **ID #**_______________________________________
Dental Insurance Name: ______________________________ **ID#** _____________________________________

Parent/Legal Guardian Information: (please circle) Mother/Father Step Mother/Father Guardian

Parent's Marital Status: (Please Circle) Married Divorced Separated Widowed Single

Name: ____ Date of Birth: __________________________

Social Security #: _______________________ Email: ____

Address: ____
Cell / Other Phone _________________________ Work Phone #: __________________________
Employer: ____
Medical Insurance Plan Name:________________________ **ID #**_______________________________________
Dental Insurance Name: ______________________________ **ID#** _____________________________________

Emergency Contact other than parents/legal guardian:

His / Her Name: ____ Relation:_______________________

Work Phone #: (___)____________________Home/ Cell Phone #: ___________________________

Consent for Examination and Treatment: I, the undersigned, have completed the above information to the best of my knowledge. Any information that I feel may not be complete will be discussed with the doctors and/or staff. I authorize the doctors and their dental staff to perform an oral examination, a dental prophylaxis (cleaning), and, if appropriate, topical fluoride application. Dental radiographs (x-rays) may be taken as necessary (in accordance with the guidelines established by the American Dental Association) to complete the diagnosis of my child's oral condition. If dental treatment becomes necessary, I authorize the performance of necessary treatment, medication, and therapy that is indicated in connection with dental care of the above minor patient and authorize the doctors to choose and employ such techniques and assistance as deemed fit during the treatment. I understand that I will have the right to be provided with answers to questions, which may arise during the course of my child's diagnosis and treatment.

I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it. Furthermore, I will be responsible for financial obligations incurred on this child for dental treatment.

Parent/Guardian Name (Printed) ____Date: _______________

Signature ____________________________________ Relationship:________________________________

Notice of Privacy Practices Acknowledgement:

Incidental Disclosures. **The Open Bay**. *We use an open bay in our office for most dental exams (recall appointments and sealants). This type of environment is used for many reasons including positive behavior reinforcement (kids seeing other kids behaving well). Other patients or parents in the office may overhear parts of dental treatments and, /or conversations. If you find that your child needs additional privacy, please request a closed door operatory. I have read and agree to the Notice of Privacy Practices given to me by Pediatric Dentistry of Burke, PC.*

Signature: ____ Date: __________________________

Consent for use of photographs: * (*OPTIONAL*)**

I understand that photographs and other images may be recorded to document and assist with my care. I authorize publication of such images for scientific, educational, and **promotional** purposes, not limited to but including publication on social media networks (i.e. Facebook, Pinterest, Twitter, etc.) and the Internet. We may also take pictures of your child to add to our, "No Cavity Club" bulletin board on occasion.

Parent/Guardian Name (Printed) ____Date: _______________

Signature __________________________________Relationship: ________________________________

Consent by Proxy for Dental Care: (example: Grandparents, Au Pairs, Nanny, Older Sibling over 18)

Permission to Treat Without Parent/Guardian Accompanying Child: ***(OPTIONAL)

Pediatric Dentistry of Burke must receive permission from a child's parent or legal guardian before providing treatment for any cleaning/trauma/restorative care that is non-life threatening. This form gives Pediatric Dentistry of Burke legal permission to treat your child in case you cannot accompany your child to the office for treatment. If this information is not on file with us or presented by the party accompanying your child (baby-sitter. relative. friend). Pediatric Dentistry of Burke will contact the child's parent or legal guardian before he or she is seen by the dentist. I give Consent by Proxy to:

Name of appointed Proxy(Printed)________________________ Relationship to patient: __________________
Parent/Guardian Signature: _______________________________________ Date: ____________________

Parents: *Be advised that protected patient health information may be shared with the proxy to facilitate informed decision-making.*