Charlotte Family Dentistry

Patrick Gadola, D.D.S., P.C.

Child Patient History and Information

(Confidential information: Important for our files and your health)

CHILD'S NAME _____ Birth Date _____ Age _____

Child's SS # _____

Father's Name _____ Birth Date _____

Father's Address _____ City _____ State _____ Zip _____

Father's Home Phone _____ Cell Phone _____ Bus. Phone _____

Employed By _____ Social Security # _____

Dental Ins., Address & Phone _____

Mother's Name _____ Birth Date _____

Mother's Address _____ City _____ State _____ Zip _____

Mother's Home Phone _____ Cell Phone _____ Bus. Phone _____

Employed By _____ Social Security # _____

Dental Ins., Address & Phone _____

Step-Father's Name _____ Birth Date _____

Step-Father's Address _____ City _____ State _____ Zip _____

Step-Father's Home Phone _____ Cell Phone _____ Bus. Phone _____

Employed By _____ Social Security # _____

Dental Ins., Address & Phone _____

Step-Mother's Name _____ Birth Date _____

Step-Mother's Address _____ City _____ State _____ Zip _____

Step-Mother's Home Phone _____ Cell Phone _____ Bus. Phone _____

Employed By _____ Social Security# _____

Dental Ins., Address & Phone _____

Referred By: _____

Informed Consent

Although every effort will be made to adhere to the proposed treatment plan, unforeseen circumstances may occur. If I do not remain in the dental office while my child is receiving dental treatment, I am leaving treatment up to Dr. Gadola's judgment and experience. If contact with me is not successful, should these circumstances arise, I give Patrick Gadola D.D.S. and staff the permission to change the proposed treatment plan in whichever way would most benefit my child's dental health.

Parent/Guardian's Signature _____ Date _____