Dr. Bennett Thomas DDS PC
1300 Cedar Road
Chesapeake, Va 23322
(757) 548-3238

Parent Permission Slip

I give my permission for my child(ren):

____ _________________
(Patient's Name) (DOB)

Please check all that apply

Examination:______ Necessary X-rays:______
Cleaning:______ Fluoride:_______
Dental Anestic:________ Air Abrasion:____________

In case of emergency, I can be reached at:_____________________________________

Please answer the following questions to ensure our office has all the necessary information to treat your child(ren).

Is your child taking any daily medications? _____
If yes, please list name of medication and reason:
____
Has your child been hospitalized for any reason since their last visit? _______
If yes, please give date and procedure:
____
Do you have any questions or concerns for the dentist or staff regarding your child(ren)'s dental health? ______
If yes, please state:
____
Does your child have any allergies to medication or dental anestic? _______
If yes, please specify:
____

I certify that the above information is true and accurate to the best of my knowledge

____ ________________
(Parent Signature) **(Date)**