Name: ____

Address: ____

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Home Phone: _______________ Cell: _______________________

Birthday: ___________________ School: _____________________

Sport: _______________________

Parent's Name (If minor): ____________________________________

Preferred Contact Number: ___________________________________

I give Dr. Brian Long and the staff of LifeLong Family Dentistry permission to examine ___________________ and take impressions for an athletic mouth guard. I understand these services are provided free of charge.

Patient / Guardian Signature: ____

Have you ever had dental impressions? Yes __ No __
Do you have Asthma? Yes __ No __
Are you allergic to any medications? Yes __ No __
Are you allergic to latex? Yes __ No __
Do you take any medications regularly? Yes __ No __
If Yes what are your medications? ______________________
Are you being treated by a physician for any conditions? Yes __ No __
If Yes what condition? _________________________________

Treatment Notes:
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