Child Patient Form

Urban Dental Clinic | KN 2 St, TCB Building, Kigali | +250 788 200 723

Child details

Full name: _____

Date of birth: ____ / ____ / _____

School: _____

Parent or guardian

Name: _____

Relationship: _____

Phone: _____

Email: _____

Dental history

First dental visit? Yes / No

Any dental anxiety or previous difficult visit? _____

Thumb sucking, grinding or mouth breathing? _____

Guardian consent

I consent to examination and treatment of my child at Urban Dental Clinic.

Signature: _____ Date: ____ / ____ / _____

Sample form — final version will be provided by the clinic.