Parkview Pediatric Dentistry

Pre-Sedation Check-In

Patient Name: _____

DOB: ___/___/____

Please initial the following:

_____Last Solid Food: _____AM or PM

_____Last Clear Liquids: _____AM or PM

_____For the safety of you and your child, parents are not allowed in the treatment room during Sedation.

_____You must remain in the office during your child's entire procedure. We may need to consult with you.

_____While in the office, please do not use your cell phone or any other device to video or take photographs of your child before, during, or after their procedure.

Parent/Guardian Signature _____ Date

Office Use Only

___Weight:

___Height:

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