Commerce Park Dental Group

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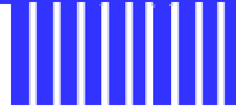

Mouth Guard Registration Form

Patient's Name ______________________ ______________ Sex ___
(Last Name) (First Name)

Parent's Name ______________________ ______________
(Last Name) (First Name)

Address ____

Phone # ___________________

Are you currently a patient of Commerce Park Dental Group? ☐ Yes ☐ No

E-mail Address _____________________________

Sports Played ____

Health Information:

Is there anything that should be known about your child's health? ☐ Yes ☐ No
(If yes, please explain below)

____

Any history of bleeding problems, HIV/AIDS or heart problems? ☐ Yes ☐ No

Does your child have any loose teeth today? ☐ Yes ☐ No

Does your child gag easily? ☐ Yes ☐ No

Do you need a strap? ☐ Yes ☐ No

I certify the above information is correct and give consent to Commerce Park Dental Group LLC to take an impression on my child for a custom fitted mouth guard.

Signature:

____

Parent Guardian Other

Payment: Cash ___________________

Check ___________________

Credit Card ___________________ Exp. ________

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