Patient Information

(Please Print)

Date:_____
(DD/MM/YY)

Child's Name: _____
(Last) (First)

❒ Male ❒ Female Age: _____ Date of Birth: _____
(DD/MM/YR)

Child's Address: _____
(Street) (City) (Prov.) (Postal Code)

Phone #: (___) _____ Cell #: (___) _____ Email Address: _____
(to be used for confirmation of appointments)

Child's Alberta Health Care #: _____

Siblings names: _____

Please tell us how you heard about our office: _____

Insurance Information:

Mother's Name: _____
(Last/First)

Date of Birth: _____
(DD/MM/YR)

Dental Insurance: ❒ Yes ❒ No
Insurance Co. Name: _____
Employer Name: _____
Group/Policy #: _____
Employees Certificate #: _____ ID #: _____

Father's Name: _____
(Last/First)

Date of Birth: _____
(DD/MM/YR)

Dental Insurance: ❒ Yes ❒ No
Insurance Co. Name: _____
Employer Name: _____
Group/Policy #: _____
Employees Certificate #: _____ ID #: _____

Medical History:

Child's Physician: _____

Phone #: _____ Date of last medical exam: _____
(DD/MM/YR)

❒ Yes ❒ No Are your child's immunizations up to date?

❒ Yes ❒ No Have you ever been told that your child needs to take antibiotics before dental treatment?

❒ Yes ❒ No Has your child ever been hospitalized, had general anesthesia, or emergency room visits?
If yes, please specify: _____

❒ Yes ❒ No ls the child taking any medications?
If yes, please specify: _____

❒ Yes ❒ No ls your child allergic to any medication, food or anything else?
If yes, please specify: _____

❒ Yes ❒ No Did your child have any medical problems in their first year?
If yes, please specify: _____

❒ Yes ❒ No Did the mother have any problems during pregnancy?
If yes, please specify: _____

❒ Yes ❒ No Is your child adopted? If yes, when: _____

(over)

Please check if your child has been treated for any of the following:

- ❒ Heart disease
- ❒ Heart murmur
- ❒ Asthma / breathing problems
- ❒ Bleeding / transfusions
- ❒ Blood disorders
- ❒ Anemia
- ❒ Sickle cell disease / trait
- ❒ Diabetes
- ❒ Hepatitis
- ❒ Seizures
- ❒ Gastric disease / reflux
- ❒ Liver disease
- ❒ Kidney disease
- ❒ Rheumatic fever
- ❒ Tuberculosis
- ❒ AIDS
- ❒ Congenital birth defects
- ❒ Cleft lip / palate
- ❒ Tonsil / adenoid problems
- ❒ Snoring
- ❒ Cerebral palsy
- ❒ Arthritis
- ❒ Endocrine / growth problems
- ❒ Spina bifida
- ❒ Cancer / tumors
- ❒ Recurrent headaches
- ❒ Significant injuries
- ❒ Adverse drug reactions
- ❒ Eyesight problems
- ❒ Speech / hearing problems
- ❒ Physical delays
- ❒ Mental delays
- ❒ Emotional disorder
- ❒ ADHD
- ❒ Autism
- ❒ Other

If yes, please specify: _____

_____

_____

Dental History:

What is the reason for your child's dental visit? Do you have any dental concerns? _____

_____

❒ Yes ❒ No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) _____ (MM/YR)

Name of previous / referring dentist: _____ Phone #: (___) _____

❒ Yes ❒ No Have previous dental experiences been positive?

If no, please explain: _____

❒ Yes ❒ No Is your child currently experiencing any dental discomfort?

If yes, please explain: _____

❒ Yes ❒ No Did you breastfeed your child? When did you stop breastfeeding? _____

❒ Yes ❒ No Does your child drink from a bottle? When did they stop? _____

❒ Yes ❒ No Do you brush your child's teeth? How often? _____

❒ Yes ❒ No Do you use fluoride toothpaste? _____

❒ Yes ❒ No Do you floss your child's teeth? How often? _____

❒ Yes ❒ No Does your child suck their fingers, thumb or pacifiers? _____

❒ Yes ❒ No Have your child's teeth ever been injured? Which teeth? When? _____

❒ Yes ❒ No Does your child play any sports? Which ones? _____

❒ Yes ❒ No Any other related dental information? _____

Consent for Dental Treatment

As the parent and I or legal guardian of the patient, I do hereby request and authorize the dentists and staff of Dental Care for Children to examine, clean, and provide dental treatment for my child. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and / or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age, which could or may include, voice control measures to ensure the safety of your child during treatment. Dental Care for Children will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments.

The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

I also hereby agree that in the event of a first-aid emergency, the dentists or staff of Dental Care for Children may administer the necessary treatment.
I understand I will be responsible for any charges incurred for my child's dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Dental Care for Children of any changes to my child's medical status.

Appointment Policy

We would like to ask for your cooperation in providing a minimum of two business days notice (48 hours) if for any reason you will be unable to keep a scheduled appointment. This consideration will allow us to accommodate those patients that may be waiting for an appointment.

If you are unable to provide notice, there may be a short notice cancellation fee.

Legal Guardian's Signature: _____ Date: _____ (DD/MM/YR)

Per Dental Care For Children: _____ Date: _____ (DD/MM/YR)