



Patient Information

(Please Print)

Date: _____
(DD/MM/YR)

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 #: _____

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 Is the child taking any medications?
If yes, please specify: _____

Yes No Is 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Significant injuries |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Adverse drug reactions |
| <input type="checkbox"/> Asthma / breathing problems | <input type="checkbox"/> AIDS | <input type="checkbox"/> Eyesight problems |
| <input type="checkbox"/> Bleeding / transfusions | <input type="checkbox"/> Congenital birth defects | <input type="checkbox"/> Speech / hearing problems |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Cleft lip / palate | <input type="checkbox"/> Physical delays |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Tonsil / adenoid problems | <input type="checkbox"/> Mental delays |
| <input type="checkbox"/> Sickle cell disease / trait | <input type="checkbox"/> Snoring | <input type="checkbox"/> Emotional disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Endocrine / growth problems | <input type="checkbox"/> Other |
| <input type="checkbox"/> Gastric disease / reflux | <input type="checkbox"/> Spina bifida | If yes, please specify: _____ |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Cancer / tumors | _____ |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Recurrent headaches | _____ |

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 / 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)