

**PATIENT Information (under age 18):**

Last name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postal Code\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: (d/m/y) \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Gender: \_\_ M \_\_ F Parents’ names:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone HOME: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PARENT’S BUS: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL: ( ) \_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you wish to receive reminders by \_\_\_\_email ? \_\_\_\_text?

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of Emergency, notify: name, phone, relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is legally responsible for payment of this account?

\_\_\_Parent \_\_\_\_ Other person: name, relationship, phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Information:**

Is today your child’s first visit to a dentist? \_\_\_\_Yes \_\_\_No

Purpose of today’s visit: \_\_\_check-up (exam) \_\_\_cleaning \_\_\_specific problem \_\_\_toothache \_\_\_other

Previous Dentist Name and location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximate date of last visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often does your child go to the dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any of the following? Please check off all that apply:

* teeth sensitive to cold
* teeth sensitive to sweet
* gums bleed when brush / floss
* bad breath
* dry mouth
* clench or grind teeth
* jaw clicks, pops or locks
* frequent headaches
* canker sores / cold sores
* food caught between teeth
* loose teeth
* chipped teeth
* history of thumbsucking
* had orthodontics (braces)
* had wisdom teeth removed

Has anyone in the family, including parent, had orthodontics (braces or appliances)? \_\_\_Y \_\_\_N \_\_\_ maybe

Has your child had any problems or complications with previous dental treatment? \_\_\_Y \_\_\_N \_\_\_ maybe

**Medical Information:**

Physician’s name, address, phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have, or ever had, any of the following? Please check off all that apply:

* Fainting easily
* Dizziness
* Epilepsy or seizures
* Hepatitis
* Jaundice
* Bleeding problems
* Asthma
* Lung disease
* Tuberculosis
* Steroid therapy
* Immune system condition
* Diabetes
* Thyroid condition
* Heart condition
* Kidney disease
* Cancer
* Mental health condition
* Eyesight problems
* Speech impairments
* Behavioral / learning problem
* Tonsil / adenoid problem
* Snoring /sleeping problem
* Hearing problem
* Ear infections

Please list any OTHER conditions or diseases that your child has or has been treated for:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***yes no ?***

Is your child taking ANY medications or non-prescription drugs of any kind?

 If YES, list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any environmental allergies?

(eg. hayfever, foods, latex / rubber, metals, acrylic)

 If YES, list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had an allergy or adverse reaction to any medicine or injections?

(eg. Penicillin, aspirin, local anaesthetics “dental freezing”, codeine, sulpha)

 If YES, list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been hospitalized for any illnesses or operations?

 If YES, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any disease or medical problems that run in your family?

(eg. diabetes, cancer or heart disease)

 If YES, list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child identify as a patient with a disability?

 If so, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent:**

I acknowledge that the information given above is true to the best of my knowledge. Should there be any change to my child’s present health status in the future, I will advise the attending dentist / hygienist.

Where my child’s physician may need to be contacted, I consent to his /her physician providing any information with regards to details in my child’s medical history which may help ensure a safe dental treatment. I understand that treatment may be delayed until all medical information required is received.

This is to certify that I, the undersigned, consent to the performing of dental procedures agreed to be necessary or advisable including the use of local anaesthetic and / or relative analgesia as indicated for my child and I will assume responsibility for fees associated with those procedures. I also consent to sharing my child’s information and discussion with dental specialists as required for my child’s overall dental health and treatment plan.

I understand the appointment policy where my child’s appointment time will be reserved time specifically for him / her and if unable to keep an appointment, the office requires 48 hours notice otherwise it may be necessary to charge for time lost.

Print Parent Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_