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 ?

Turn page over to continue →

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:________________