CHILDREN'S NEW PATIENT FORM

Patient Information

Child's First Name: _____ MI: ___ Last: _____ Preferred Name: _____

Date of Birth: _____ Age: ___ Sex: _____ Pronouns: _____ School: _____Grade: ___

Strong likes/dislikes, hobbies, interests, pets? _____

Parent of Guardian's Personal Information

First Name: _____ MI: ___ Last: _____ Preferred Name: _____ Pronouns: _____

Date of Birth: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

How do you prefer to be contacted: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email ☐ Work Phone

Emergency Contact: _____ Relationship: _____ Phone: _____

Name of Physician: _____ Physician's Phone: _____

Pharmacy: _____ Pharmacy's Phone: _____

PRIMARY BENEFIT INFORMATION

POLICY HOLDER: _____ DOB: _____

INSURANCE COMPANY: _____ EMPLOYER: _____

PLAN/POLICY NUMBER: _____ I.D./CERTIFICATE NUMBER: _____

SECONDARY BENEFIT INFORMATION

POLICY HOLDER: _____ DOB: _____

INSURANCE COMPANY: _____ EMPLOYER: _____

PLAN/POLICY NUMBER: _____ I.D./CERTIFICATE NUMBER: _____

Patient Health History

Does your child have a history of:

- ADD, ADHD, Autism
- A.I.D.S/HIV Positive
- Anemia
- Asthma
- Blood Disease
- Bone Disease
- Cancer
- Cerebral Palsy
- Chest Pain
- Circulatory Problems
- Congenital Heart Lesions
- Convulsions/Seizures
- Diabetes
- Drug Addiction
- Excessive Bleeding
- Epilepsy
- Hay Fever
- Head Injuries
- Hearing Impaired
- Heart Disease
- Heart Valve, Murmur
- Hepatitis/Liver Disease Type(s): _____
- Hepatitis Carrier
- High Blood Pressure
- HPV
- Infectious Endocarditis
- Jaundice
- Kidney Disease/Dialysis
- Lupus
- Low Blood Pressure
- Malignancies
- Mitral Valve Prolapse
- Neck or Back Problems
- Osteoporosis
- Pacemaker
- Pregnancy
- Prosthetic Joints
- Psychiatric Care
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Scarlet Fever
- Sexually Transmitted Infections
- Sinus Problems
- Smoking
- Stomach Ulcers
- Stroke
- Thyroid Disease
- Tuberculosis

Medical Questionnaire

List any medications that your child is taking including nonprescription drugs, supplements, natural products, and/or vitamins: _____

_____

ALLERGIES/SENSITIVITIES:

☐ Aspirin ☐ Local Anesthetic
☐ Bananas ☐ Metals
☐ Codeine ☐ Penicillin
☐ Latex ☐ Red Dye
☐ Other Dental Materials: _____

Is your child allergic to any medications? Yes No

If yes, please list: _____

_____

Other allergies: _____

_____

Date of last medical exam: _____

Is your child currently under the care of an MD? Yes No If yes, what for? _____

Has your child ever been hospitalized? Yes No If yes, what for? _____

Is your child taking or have they ever taken bisphosphonates? Fosmax or Actone for osteoporosis, chemotherapy, etc.?

Yes No If yes, is it taken orally or by IV? _____

Is there anything else about your child's health that we should know? _____

_____

Dental History Information

Main dental concern regarding your child: Broken teeth Crooked teeth Speech habits Oral hygiene Other

Any mouth habits (e.g. Thumb/finger sucking): _____

Name of their previous dentist: _____ Number of years as patient: _____ Age of first dental visit: _____

Date of last dental visit: _____ Date of last dental cleaning: _____ Date of last X-Rays: _____

Is your child nervous about seeing a dentist? Yes No If yes, please specify: _____

Does your child have or had any of the following?

- ○ Bad breath
- ○ Bleeding gums
- ○ Broken fillings
- ○ Dry mouth
- ○ Fingernail biting
- ○ Frequent headaches
- ○ Food impaction
- ○ Grinding/clenching their teeth
- ○ Loose teeth
- ○ Mouth breathing
- ○ Sensitivity to hot, cold, sweets, or pressure
- ○ Sores/blisters/swelling on gums, lips, or cheeks
- ○ Other: _____

How often does your child brush their teeth? _____ How often does your child floss their teeth? _____

Has your child ever:

Been treated for periodontal disease? Yes No

Had an oral cancer screening? Yes No

Had orthodontic treatment (e.g. braces)? Yes No If yes, please specify: _____

Had any teeth extracted? Yes No If yes, when and why? _____

Had complications from extractions? Yes No If yes, please specify: _____

Used nitrous oxide or oral sedation for dental appointments? Yes No If yes, please specify: _____

General Release Statement

I certify that I have read, understood, and accurately completed the personal medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me, and I consent to my physician being contacted regarding specific medical questions. I authorize the dentist to perform necessary diagnostic procedures and treatment as necessary or advisable for my child.

I understand that I am financially responsible to the dentist for the dental services provided even of my insurance coverage may not be all inclusive.

Payments are to be made at each visit for services rendered.

Cash, Debit, Mastercard and Visa are acceptable forms of payment.

Interest of 2% per month on late payments will be charged automatically.

Parent/Guardian Name _____ *Date* _____

Signature _____ *Reviewed by Dentist* _____