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FAMILY DENTISTRY

KIDS' NEW PATIENT FORM

Patient name _____ _____ _____

Surname Given Names Preferred name

Name of parents and/or caregivers: _____

Emergency contact other than parents (please include name, relationship to child, and phone number)

_____

Address _____

Phone number _____ _____ _____

Home Cell Work

E-mail _____

Preferred contact method: □ Phone □ E-mail □ Text Message

DENTAL INSURANCE INFORMATION

Please complete this section if you have coverage under a dental insurance plan

Primary Insurance Plan

Company:

_____

Plan Number:

_____

Subscriber ID Number:

_____

Secondary Insurance Plan (if applicable)

Company:

_____

Plan Number:

_____

Subscriber ID Number:

_____

MEDICAL HISTORY

Please provide the name and contact information for your child's medical doctor(s) – general practitioners and specialists

_____

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When was your child's last medical check-up? _____

What pharmacy do you generally use? _____

Please provide your child's OHIP number _____

Is your child being treated for any medical condition at present? Do they have any medical conditions requiring regular check-ups by their doctor?

_____

Is your child taking any medications at this time? Please include inhalers and non-prescription drugs

_____

_____

Does your child have any allergies or unfavorable reactions to drugs, including antibiotics and local anaesthetics? Please describe what happens:

_____

_____

Does your child have asthma or trouble breathing?

_____

Has your child ever been hospitalized for illness or injury?

_____

Does your child bleed for a long time following injuries, have frequent nosebleeds, or bruise easily?

_____

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Does your child have any physical, mental, emotional, or learning disabilities?

_____

Are your child's immunizations up to date? If not, please explain

_____

Is there any reason to think that you or your child may have been exposed to, or at risk of Hepatitis C or HIV infection? □ Yes □ No

Has your child ever been diagnosed as having, or been treated for any of the following?

□ Autism
□ Bleeding disorders
□ Cancer
□ Cerebral Palsy
□ Chicken pox
□ Cleft lip or cleft palate
□ Diabetes
□ Epilepsy or seizures
□ Fainting spells
□ Gastrointestinal issues (digestive)
□ Heart disease
□ Herpes/cold sores
□ Malignant hyperthermia
□ Muscular problems
□ Nervous system problems (brain and nerves)
□ Orthopaedic problems (bones and skeleton)
□ Rheumatic fever
□ Speech issues
□ Tonsils/adenoids infections or removal

If yes, please describe: _____

_____

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DENTAL HISTORY

What brings you to our office? Do you have any immediate dental concerns?

_____

When was your last dental visit and what was done? When were your most recent dental radiographs (x-rays) taken?

_____

I routinely saw my dentist every

□ 3 months □ 6 months □ 9 months □ 12 months □ Not routinely

How nervous are you about dental treatment on a scale of 1 (low) to 10 (high)? _____

Have you ever had an unfavorable dental experience or complications as a result of dental treatment? Please explain:

_____

Please indicate any concerns or conditions that apply to you:

□ Bleeding Gums

□ Bruxism (clenching and grinding)

□ Difficulty with freezing

□ Dry Mouth

□ Gag Reflex

□ Gum Recession

□ Jaw Joint Concerns (TMJ/TMD)

□ Nail Biting or other habits

□ Orthodontics

□ Periodontal disease (gum disease)

□ Sensitivity

□ Teeth shifting position

What, if anything, would you change about your smile?

_____

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Patient Release

I, the undersigned, certify that I have provided an accurate and complete medical and dental history and have not knowingly omitted any information. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care

Signature _____ Date _____