mccabe
FAMILY DENTISTRY

CHILD'S NEW PATIENT FORM

First Name _____ Last Name_____ Date of Birth_____(d/m/y)

Parent/Caregiver names _____

Address_____

Home Phone _____Cell_____Work_____Email_____

Preferred contact method: ☐ Phone ☑ E-mail ☐ Text

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

Emergency contact, other than parents? (Include Name, relationship, and best phone number to contact)_____

Name, Address & Phone Number of Physician_____

Last time your child saw their Physician_____ Reason_____

Date of last Physical_____

Is your child being treated for any condition at present or within the last year by your physician or a specialist? Yes ☐ No ☑

Condition_____

Specialist's Name, Address & Phone Number_____

Have there been any changes to your child's general health in the last 3-5 years? Yes ☐ No ☐

Please explain._____

_____

Has your child had any surgeries or hospitalization in the last 3- 5 years? Yes ☐ No ☐

Please explain._____

Please list all medications, non-prescription medications, herbal supplements or vitamins you are currently taking – please include dosage and frequency.

_____

_____

_____

_____

Does your child have any allergies or adverse reactions to medications, latex, food, etc.? Yes ☐ No ☐

Please list._____

Preferred Pharmacy Information_____

Has your child ever been diagnosed with cancer? Yes ☐ No ☐

Please indicate type and location: _____

Has your child had chemotherapy? Yes ☐ No ☐

Please indicate date of last treatment. _____

Has your child had radiation therapy? Yes ☐ No ☐

Please indicate date of last treatment. _____

Has your child ever been instructed to take antibiotics prior to a dental visit? Yes ☐ No ☐

Please indicate reason._____

Please indicate if your child has had or currently has any of the following conditions. Please include details.

Condition	Never Had	Currently Have	History of	Date of last incident and details of medications/treatment required
Heart disease: Heart attack, heart failure, chest pain (specify)				
Congenital heart defect or heart murmur (specify)				
Heart Valve concerns/Artificial valves (indicate date placed)				
Infective Endocarditis				
Anemia				

Conditio	Never Had	Currently Have	History of	Date of last incident and details of medications/treatment required
Blood disorder (specify)				
Prolonged bleeding, bruising easily, slow healing (specify)				
Auto-immune conditions: (ex. Lupus) (specify)				
Cancer (specify)				
Lung disease: Tuberculosis, Emphysema, bronchitis, pneumonia (specify)				
Asthma or shortness of breath (specify)				
Sinus problems, hay fever or seasonal allergies (specify)				
Diabetes: type I, type II (specify) Controlled? Yes/No				
Thyroid disease: hyperthyroidism, hypothyroidism, (specify)				
Liver diseases (jaundice, Hepatitis, etc.) (specify)				
Bone diseases				
Kidney disease				
Organ transplant				
Oral Herpes, cold sores, (specify)				
Eye disease: glaucoma, cataracts, blindness (specify)				
Do they wear contacts lenses or hearing aids (specify)				
Rheumatic fever, cerebral palsy, multiple sclerosis, Parkinson's disease (specify)				

Condition	Never Had	Currently Have	History of	Date of last incident and details of medications/treatment required
Epilepsy, seizures, chronic exhaustion or fainting spells (specify)				
Paralysis				
ADD/ADHD, Autism (specify)				
Clinical depression, anxiety, psychiatric treatment (specify)				
Sleep apnea, snoring, or difficulty sleeping (specify)				

Any other condition that was not mentioned above or anything else you would like us to know about your child?

_____

Where does your child spend the day? (Home, daycare, school etc)

_____

What does your child like to do in their spare time? What are their interests?

_____

PATIENT RELEASE

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

_____ _____

Signature Date

DENTAL HISTORY

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

_____

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

_____

My child routinely saw the dentist every

☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Not routinely

How nervous is your child about dental treatment on a scale of 1 (low) to 10 (high)? _____

Has your child ever had an unfavourable dental experience or complications as a result of dental treatment? Yes ☐ No ☐
Please explain:

_____

Please indicate any concerns or conditions that apply to your child:

☐ Bleeding Gums
☐ Bruxism (clenching/grinding)
☐ Difficulty with freezing
☐ Dry Mouth
☐ Gag Reflex
☐ Gum Recession
☐ Jaw Joint Concerns (TMJ/TMD)
☐ Nail Biting or other habits
☐ Orthodontics
☐ Periodonta/Gum Disease
☐ Sensitivity
☐ Teeth shifting position

What is your child's oral care routine?

☐ Brushing Frequency? _____x per day
☐ Flossing/floss sticks Frequency? _____x per day
☐ Fluoride toothpaste Frequency? _____x per day
☐ Mouthrinse Frequency? _____x per day

How do you assist your child with any of their oral care?

_____

Please indicate what, if any, oral habits your child has. (e.g. thumb sucking, soother, nail biting)

_____

What type and how often is your child snacking? Bottle/Sippy cup at bedtime? Please indicate type of snacks and/or beverages.

_____

We ask you to review the following office policies prior to joining our practice.

FINANCIAL POLICY

The patient assumes all financial responsibility for any dental treatment incurred. Patients are required to pay for their dental services, in full, on the day of treatment.

We do not offer assignment of benefits (direct billing) at this practice. All dental insurance plans are different and not all services are covered by every insurance plan. We are pleased to send estimates to your insurance provider on your behalf. However, it is ultimately your responsibility to be aware of your plan details and coverage prior to consenting to dental services. The patient is responsible for charges related to dental treatments rendered that are not covered by insurance for any reason

Please initial that you have read and understood our financial policy

BOOKING POLICY

Your appointment time has been reserved specifically for you. If you are unable to keep your appointment, we ask you to be mindful of the fact that this time slot could be used by another patient in need of dental treatment. We ask for 48 hours' notice for any changes to your appointment. If you are unable to provide this notice, a fee of $50.00/hour of time scheduled will be applied to your account to compensate for lost time and inconvenience to our other patients and dental providers. Any patient who fails to attend multiple dental appointments may be dismissed from the practice.

I, _____, have read the above conditions of treatment and payment and agree to their content.

_____ _____

Patient/Guardian Signature Date