CHILD NEW PATIENT REGISTRATION

Dear Parent/Guardian:
Welcome to our office. Your feelings and desires are important to us. We would like for you to assist us by answering the following questions for your child. This information will be of help and will be treated confidentially. Thank you for your patience.

PERSONAL INFORMATION

Child's Name_____ Birthdate(day/mo/yr) _____
(last) (first)
Home Phone_____ Business Phone_____ Cell/Pager_____
Street No. _____City_____
Province_____ Postal Code_____
Name of Mother (include last name if different)_____
Name of Father (include last name if different)_____

Person responsible for account:
__Parent Other _____
Employer_____Occupation_____
Business Address_____City_____
Do you have Dental Insurance? Yes__ No__
Name of Insurance Co. _____
Group Policy No._____ Certificate No._____
Secondary Insurance Co._____
Group Policy No._____ Certificate No._____
In case of emergency, please notify_____
Relationship_____ Phone No._____
Whom may we thank for referring you?_____

Reason for today's visit: Examination__ Emergency__ Other_____

MEDICAL HISTORY QUESTIONAIRE

Family Physician_____ Phone_____
Address_____ City_____
Medical Specialist_____ Phone_____
Address_____ City_____
Health Card No. (for drug prescriptions)_____

Is your child being treated for any medical condition at the present or been treated within the last year? Y/N Maybe
Details, if yes _____
_____
_____
When was your child's last visit to a physician?_____
Please give reason:_____
Has there been any change in your child's general health in the past year? Y/N Maybe
Details, if yes _____
_____
Is your child taking any medications or non-prescription drugs of any kind Y/N Maybe
If "yes", please list with dosage:
_____
_____
_____
Does your child have any allergies (e.g. latex) Y/N Maybe
Has your child ever had a peculiar or adverse reaction to any medicines or injections? (e.g. penicillin, codeine, aspirin or local anesthetic) Y/N Maybe
Does your child have any heart or blood pressure problems? Y/N Maybe
Does your child have a heart murmur or mitral valve prolapse? Y/N Maybe
Has your child ever had Rheumatic Fever? Y/N Maybe
Does your child have or ever had jaundice, hepatitis or liver disease? Y/N Maybe
Have you ever been told that your child should not give blood? Y/N Maybe
Does your child have any conditions that could affect his/her immune system(e.g. AIDS, HIV positive, leukemias, etc) Y/N Maybe
Does your child have a tendency to bruise easily or bleed for a prolonged period of time after being injured? Y/N Maybe
Has your child ever been hospitalized for any serious illness or operations? Y/N Maybe

Does your child have or ever had any of the following? Please check off only those that apply.
__chest pain __bronchitis __tuberculosis __arthritis __heart attack __emphysema
__epilepsy __diabetes __stroke __asthma __stomach ulcers
__prosthetic joint __kidney disease __cancer __eating disorder
__drug/alcohol dependency __psychiatric disorder __radiation therapy __chemotherapy
__none of the above

Please list and describe any conditions or diseases not listed in the previous page that your child may have or has ever had.

_____
_____
_____

Follow-up information to medical questionnaire:

_____
_____
_____
_____

Medical Alert:

DENTAL HISTORY QUESTIONAIRE

Does your child have any emotional concerns regarding his/her dental visit? __anxiety __pain other concerns _____
_____
_____

When was your child's last dental visit? _____ last dental x-rays? _____
Previous dentist's name _____Phone No. _____
Address _____ City _____
Reason for changing dentist _____

Has your child been seeing a dentist regularly?	Y/N	Maybe
Does any of your child's teeth ache?	Y/N	Maybe
Has your child ever been advised to take antibiotics before dental visits?	Y/N	Maybe
Does your child's gums bleed when he/she brushes?	Y/N	Maybe
Does your child have any pain when he/she chews?	Y/N	Maybe
Do you feel that your child has bad breath?	Y/N	Maybe

Has your child ever been in a vehicle accident or experienced any blows to his/her jaw? Y/N Maybe

Has your child ever had any implant surgery in one or both of their jaws or jaw joints? Y/N Maybe

If you have answered "yes" to the last question, who performed the surgery and where and when was it done? _____

_____

Has your child ever seen a dental specialist? (e.g. paedodontist) Y/N Maybe

Details, if yes: _____

Has your child ever had orthodontic treatment ("straightening of teeth") in the past? Y/N Maybe

Details, if yes: _____

Please list anything else not mentioned above regarding your child's past dental history.

_____

_____

Are there any dental concerns you would like to discuss about your child? _____

_____

_____

FINANCIAL RESPONSIBILITY

Unless otherwise arranged, payment for service is required on the day of the treatment in rendered.

INSURANCE

In order to prevent misunderstanding about dental insurance, we wish our patients to know that all professional services are CHARGED DIRECTLY TO THE PATIENT and the PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF BILLS ON THE DAY treatment is provided. We will prepare necessary reports to help collect your benefits from insurance companies. However, each fee is individual and may vary with different cases. Therefore, collection of benefits may vary slightly.

PATIENT RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I authorize the dentist to release all information necessary to secure payment of benefits from my dental insurance company. I understand that responsibility for payment for the dental services provided for myself and my dependents is mine and I will assume responsibility for fees associated with these services.

Parent/Guardian signature _____ Date(d/m/y) _____

Reviewed by Treating Dentist _____ Date(d/m/y) _____