SUMMERSIDE DENTAL

Child Health/Dental History Form

Patient's Name LAST	FIRST	INITIAL	Date of Birth
Parent's/Guardian's Name	Relationship to Patient		Parent's Date of Birth
Address PO OR MAILING ADDRESS	CITY	PROV	PC
Phone HOME / CELL	EMAIL		Sex M ☐ F ☐
Current Height	Current Weight	Alberta Personal Health Number	
Main Concern with child's teeth			

Has the child had any history of, or conditions related to, any of the following? Please check the box of all problems / conditions which your child has experienced:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV +/AIDS	☐ Murmur	☐ Sickle cell
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mononucleosis	☐ Thyroid
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Mumps	☐ Tobacco/Drug Use
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex allergy	☐ Pregnancy (teens)	☐ Tuberculosis
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Rheumatic fever	☐ Other
☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Seizures	

Please list the name and phone number of the child's physician: ☐ I do not have a current physician

Name of Physician _____ Phone _____

Child's History

		Y	N
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time: _____ If yes, please list:	☐	☐
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please specify:	☐	☐
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain:	☐	☐
4.	Has the child ever had a serious illness? If yes, when: _____ Please describe:	☐	☐
5.	Has the child ever been hospitalized?	☐	☐
6.	Does the child have a history of any other illnesses? If yes, please list:	☐	☐
7.	Has the child ever received a general anesthetic?	☐	☐
8.	Does your child grind his/her teeth?	☐	☐
9.	Does the child have any speech difficulties?	☐	☐
10.	Has the child physically, mentally, or emotionally impaired?	☐	☐
11.	Does the child experience excessive bleeding when injured?	☐	☐
12.	Is the child currently being treated for any illnesses?	☐	☐
13.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date:	☐	☐
14.	Has the child had any problem with dental treatment in the past?	☐	☐
15.	Has the child ever had dental radiographs (x-rays)?	☐	☐
16.	Has the child ever suffered any injuries to the mouth, head or teeth?	☐	☐
17.	Has the child had any orthodontic treatment?	☐	☐
18.	Is fluoride toothpaste used?	☐	☐
19.	How many times are the child's teeth brushed per day? _____		
20.	Does the child suck his/her thumb, fingers or pacifier?	☐	☐
21.	Does the child participate in active recreational activities?	☐	☐
22.	Does your child predominantly breathe through his/her mouth?	☐	☐

How did you hear about Summerside Dental? _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and consent to my child receiving the dental treatment hereby recommended, or I may agree upon a referral to a pediatric dental specialist. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have make in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

Consent Form

All professional services performed are the PERSONAL RESPONSIBILITY OF THE PATIENT and payment is expected when the treatment is rendered. Claims are submitted electronically to assist in collecting the reimbursement of your benefits. Direct billing to an insurance company may be allowed under special circumstances with a credit card number held for any differences. Our treatment plans are not based primarily on what is covered by insurance, but on individual patient needs and preferences

APPOINTMENTS:

Appointment times are reserved for you. If unable to keep an appointment, please give us at least 24 hours notice to make alternative scheduling arrangements, or a cancellation fee may be changed.

PERMIT FOR DENTAL PROCEDURES

This is to certify that I (the parent/guardian), will consent to the performing of the dental and surgical procedures agreed to be necessary or advisable, when I have been informed of my options and understand the risks and benefits to my satisfaction. I (the parent/guardian) acknowledge that no guarantee has been provided to me as to the results of treatment, and I assume the risks inherit in dental procedures.

PRIVACY ACT AND ELECTRONIC SUBMISSION:

I (the parent/guardian) understand the required standards of personal information confidentiality are being met in accordance with the Health Professionals Act and the Alberta Personal Information Protection Act. I (the parent/guardian) hereby authorize the release of information contained in claims to be submitted electronically or by mail to my insurance company.

I explicitly consent to receiving emails and text messages from Summerside Dental

I have read and understand the above conditions and content

NAME OF PATIENT: _____

SIGNATURE OF PATIENT OF PARENT/GUARDIAN: _____

E-MAIL: _____

DATE: _____