PEDIATRIC PATIENT INFORMATION

Patient Name: _____ Nickname: _____ **Date:**_____
Last First

Address: _____

_____ Home :(____) _____-_____
City Province Postal Code

Date of Birth: _____ /_____ /_____ Sex: ☐ Male ☐ Female Alberta Health Care No._____
Month Day Year

Mother's Name: _____ Home(____) _____-_____ Work (____) ____-_____ Ext: _____ Cell(___) _____-_____

Father's Name: _____ Home(____) _____-_____ Work (____) ____-_____ Ext: _____ Cell(___) _____-_____

Child's Physician: _____ Physician's Phone: _____

Who may we thank for referring you to our office? _____

Are there any dental concerns that you would like us to evaluate today? YES _____ NO _____
If yes please describe: _____

DENTAL BENEFITS

First Insurance Coverage: Insurance Company Name: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____/_____/_____ Employer: _____
Month Day Year

Group Number: _____ ID #:_____

Second Insurance Coverage: Insurance Company Name: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____/_____/_____ Employer: _____
Month Day Year

Group Number: _____ ID #:_____

MEDICAL HISTORY

1. Date of last medical exam _____
2. Is your child under medical care?……. ☐ **YES** ☐ **NO**
If so, for what? _____
3. Has your child been hospitalized?..... ☐ **YES** ☐ **NO**
If so, for what? _____
4. Is your child taking any medication?..... ☐ **YES** ☐ **NO**
If so, what? _____
5. Does your child snore on a regular basis?..... ☐ **YES** ☐ **NO**
6. Does your child have any allergies to any of the following?

Aspirin	□Yes	□ No	**Latex**	□Yes	□ No
Anesthetic	□Yes	□ No	**Penicillin**	□Yes	□ No
Codeine	□Yes	□ No	**Sulpha**	□Yes	□ No
Iodine	□Yes	□ No			

Other _____

7. Has your child ever been advised that antibiotics are required prior to dental procedures?..... ☐ **YES** ☐ **NO**

8. Has your child had any history of any of the following?

ADD / ADHD	☐ Yes	☐ No	**Diabetes**	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	**Epilepsy**	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	**Hearing Problems**	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	**Heart Disease**	☐ Yes	☐ No
Autism	☐ Yes	☐ No	**Heart Murmur**	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	**Kidney Disease**	☐ Yes	☐ No
Brain Injury	☐ Yes	☐ No	**Leukemia**	☐ Yes	☐ No
Cancer or Tumor	☐ Yes	☐ No	**Liver Disease**	☐ Yes	☐ No
Cardiovascular Disorder	☐ Yes	☐ No	**Rheumatic Fever**	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No	**Seizures**	☐ Yes	☐ No
Cleft Lip / Palate	☐ Yes	☐ No	**Sleep Apnea**	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No	**Tuberculosis**	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No			

CONSENT: The undersigned hereby consents to the taking of x-rays, study models, photographs or any other diagnostic aids deemed appropriate by him to make a thorough diagnosis of the patient's dental needs. I authorize the Dentist to perform all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered.

Signature of Parent / Guardian: _____ Date: _____ Staff Signature: _____