Redcliff Family Dental Centre

Today's Date:_____

Child's Name: _____ Health Care #:_____

Date of Birth: _____ Age: _____ Gender: M F

Primary Address:_____ Postal Code: _____

Mother/ Legal Guardian's Name: _____ Cell:_____

Email Address: _____

Father/Legal Guardian's Name: _____ Cell: _____

Email Address: _____

Home Phone Number: _____

Emergency Contact: _____ Phone#:_____

How did you hear about our office? _____

Physician: _____ Previous Dentist: _____

Medical History

Has your child seen a doctor in the past year? If yes, why? _____
Does your child have any drug allergies that you are aware of? Yes / No If yes, please list:

_____

Does your child have a Latex allergy? Yes / No
Is your child presently taking any medication(s)? Yes / No If yes, please list: _____
Has your child ever been hospitalized? Yes / No If yes, for what reason:_____
Has a physician/specialist ever recommended taking antibiotics prior to dental treatment or surgery? Yes / No
Does your child require any special care due to a medical condition? Yes / No If yes, please explain:

_____

Please circle any of the following conditions that apply to your child, past or present:

ADD/ADHD	Chronic Allergies	Liver Problem
Allergies	Diabetes	Migraines/ Headaches
Any Blood Disease	Epilepsy	Nervous Problems
Arthritis	Heart Surgery	Respiratory Disease
Asthma	Heart Ailment or Murmur	Sinus Problems Problems
Autism	Hepatitis	Stomach or Intestinal
Cancer	Kidney Problems	

Are there any conditions not listed that we should be aware of?_____

Dental History

When was their last complete dental exam? _____ Were x-rays taken? Yes / No
Has your child ever had Freezing? Yes / No Any complications? Yes / No If yes, explain:_____
Do you feel your child's daily dental care is adequate? Yes / No
How many times per week do you supervise or assist with your child's brushing? _____
Does your child suck his/her thumbs, fingers or pacifier? Yes / No
How comfortable would you say your child is with today's visit? (1-10) 1-Apprehensive 10- Excited: _____
Do you have concerns with your child's teeth? _____
Is your child experiencing any discomfort or pain in their mouth/teeth? _____
Do you have any concerns not covered on this form? _____

Permission to Treat, Release of Information & Privacy

This is to certify that I, the undersigned, as parent or guardian of the above mentioned child, consent to the performance of any dental and oral surgery procedures agreed to be necessary or advisable. Including the use of local anesthetic as needed. I will assume full responsibility for fees associated with these procedures. I authorize the release to my insurance company and/or plan administrator any information contained in manual or electronic claims.

Parent/Guardian's Signature: _____ Date: _____