Child's Play
Pediatric Dentistry

New Patient Questionnaire

Today's Date(dd/mm/yyyy):_____

Child's Name: _____ **Preferred Name:** _____

Male ☐ **Female** ☐ **Date of Birth (dd/mm/yyyy):** _____ **Care Card #:**_____

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

Child's Specialist:_____ **Phone:**_____

Referred by/How did you hear about us?_____

Mother/Guardian:_____

Date of birth (dd/mm/yyyy):_____

Married ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐

Address:_____

City:_____ **Postal Code:**_____

Home Phone:_____ **Cell phone:**_____

Place of Employment:_____

Bus. Phone:_____

Email address:_____

Father/Guardian:_____

Date of birth (dd/mm/yyyy):_____

Married ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐

Address:_____

City:_____ **Postal Code:**_____

Home Phone:_____ **Cell phone:**_____

Place of Employment:_____

Bus. Phone:_____

Email address:_____

In case of emergency and a parent cannot be reached, notify:_____ **Phone:**_____

Dental Insurance Information:

#1). Policy Holder:_____ **Insurance Name:**_____
Cert/ID #:_____ **Dep. #:**_____ **Group/Policy #:**_____

#2). Policy Holder:_____ **Insurance Name:**_____
Cert/ID #:_____ **Dep. #:**_____ **Group/Policy #:**_____

#3). Policy Holder:_____ **Insurance Name:**_____
Cert/ID #:_____ **Dep. #:**_____ **Group/Policy #:**_____

Dental History:

- Who is your family dentist? _____ Phone:_____
- What is the main reason for your visit with us today? _____
- How often does your child see the dentist? _____ Date of Last Visit:_____
- Has your child ever had any injuries to their head, mouth or teeth? Y N
  - If yes, please explain:_____
- Does your child take fluoride vitamins? Y N
- Does your child use fluoride toothpaste? Y N
- Does your child have any oral habits (ex. Thumb-sucking, grinding)? Y N If yes, specify:_____
- Has your child had any negative experiences with dentists or doctors? Y N
  - If yes, please explain:_____
- Has your child seen any other dental specialist (ex. Orthodontist, Endodontist)? Y N
  - If yes, who: _____

Child's Play consent for treatment and office policies:

Parent (Guardian) Consent for Minors (<19 years)

I, the undersigned, consent to Dr. Coveney, Dr. Grant, and/or Dr. Santos, assisted by their dental staff, to perform an examination and dental and/or oral surgery procedures deemed to be necessary or advisable, including, but not limited to, the taking of radiographs (dental x-rays), use of diagnostic aids, and use of local anesthesia on my child. I also consent to the release of any necessary dental and/or medical information with other health professionals if deemed necessary for appropriate treatment. I will assume responsibility for fees associated with these procedures and understand that fees are due at the time of service.

Parent/Guardian Signature: _____ Date: _____

Child's Play Policy on Missed and Late Appointments

In order to provide the best possible care for all of our valued dental patients, we kindly ask that you give us a *minimum* of 48 business hours notice if you are unable to keep your child's appointment, so that we may better accommodate other patients. Short notice cancellations (<48 business hours) or missed appointments may result in a cancellation fee. Being late for an appointment may result in rescheduling that appointment in order to best serve the remainder of the patients scheduled that day.

Signature of acknowledgement: _____ Date: _____

Child's Play Pediatric Dentistry Privacy Policy

Our dental office is responsible for all personal information under our control, and the policies and practices we employ for handling this information to ensure our office complies with the provincial privacy legislation in force. For more information on our policies or, should you have any concerns, please contact our office privacy officer whose contact information will be given to you upon request. As a dental patient, or consenting parent for a child/minor patient, the personal information is requested to ensure safe and appropriate dental care. It will only be collected, used and disclosed for this purpose. Similarly, financial information will also be collected, used and disclosed for the payment of services rendered.

Consent to collection and use of personal information: _____ Date: _____

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Our mission is to be the best pediatric dental office possible. We are committed to being an enthusiastic team, working with you for your child's optimal oral health. Our patient's emotional and physical well-being is our number one priority and we will strive everyday to make it fun for them as well as safe and rewarding.

Medical History Questionnaire

Date:_____

Child's Name:_____ Date of Birth:_____

Name of parent or guardian filling out this form:_____

Medical History:

- Is your child presently under the care of a physician for anything other than regular care? Y N
  - If so, for what? _____
- Are your child's immunizations current? Y N
- Is your child allergic to anything? Y N
  - If yes, what (eg. Latex, penicillin)? _____
- Is your child taking *any* medications or supplements? Y N
  - If yes, what and what dose? _____
- Has your child had general anesthetic? Y N
  - Please specify reason: _____
- Has your child's doctor ever recommended antibiotics before dental treatment? Y N

Does your child have or has your child ever had a history of:

1. Heart murmur Y N
2. Heart disease or rheumatic fever Y N
3. Asthma Y N
   *Severity:*_____
4. Seizures/Epilepsy Y N
5. Diabetes Y N
6. Liver Disease Y N
7. Kidney Disease Y N
8. Thyroid Disease Y N
9. High/Low Blood Pressure Y N
10. Genetic Disorder Y N
    Diagnosis:_____
11. Fainting Y N
12. Premature Birth Y N
13. Cancer Y N
    *Diagnosis:*_____
14. Bleeding Problems Y N
15. Behavioural Issues Y N
    Eg. Autism, ADHD, Depression
    *If so, specify:*_____
16. Developmental Delay Y N
    If so, specify:_____
17. Sleep Apnea Y N

Additional Notes:_____

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Has your child had a history of any conditions not included above? Y N

Please specify:_____

_____

I hereby certify that I have read and understand the previous information and that it is accurate, true and complete to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health. If there is ever a change in my child's health, I will inform Child's Play Pediatric Dentistry at my child's next dental appointment without fail._____ _____(Initial)

Signature:_____ Date:_____