ALL Care DENTAL

New patient form

FOR A PATIENT UNDER 18

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A parent or guardian fills this in and signs page 2. Print clearly, or type into it on screen. Bring it to your child's first visit.

OFFICE USE · CHART NO.	MEDICAL ALERT

ABOUT YOUR CHILD

CHILD'S LAST NAME	GIVEN NAMES	CALLED AT HOME	DATE OF BIRTH	TODAY'S DATE

APT.	STREET ADDRESS	CITY	POSTAL CODE

SCHOOL	GRADE	WHO IS BRINGING YOUR CHILD?	RELATIONSHIP

CHILD'S FAMILY PHYSICIAN	PHONE	PREVIOUS DENTIST	ADDRESS OR PHONE

PERSON RESPONSIBLE FOR THE ACCOUNT	WHOM MAY WE THANK FOR REFERRING YOU?
◯ Parent or guardian below ◯ Other: _____	

PARENT OR GUARDIAN

NAME	RELATIONSHIP	CELL PHONE	HOME PHONE	EMAIL

SECOND PARENT OR GUARDIAN	RELATIONSHIP	CELL PHONE	EMAIL

IF WE CANNOT REACH YOU, NOTIFY	RELATIONSHIP	PHONE

DENTAL INSURANCE

IS YOUR CHILD COVERED?	NAME OF THE PLAN HOLDER	INSURANCE COMPANY	EMPLOYER
◯ Yes ◯ No			

GROUP POLICY NUMBER	CERTIFICATE OR ID NUMBER	PLAN HOLDER'S DATE OF BIRTH

YOUR CHILD'S MEDICAL HISTORY · confidential

		YES	NO
1.	Is your child in good health?	◯	◯
2.	Is your child under the care of a physician at present? If yes, for what? _____	◯	◯
3.	Has your child ever had a serious illness, an operation or a stay in hospital?	◯	◯
	If yes, please tell us more: _____		
4.	Is your child taking any medicines at present?	◯	◯
	A _____ B _____ C _____		
	D _____ E _____ F _____		
5.	Has your child ever had a reaction to any kind of medicine?	◯	◯
	To: ☐ Penicillin ☐ Sulfa drugs ☐ Aspirin, Advil or similar ☐ Codeine Other: _____		
6.	Does your child have any other allergies, including foods or latex? If yes, to what? _____	◯	◯
7.	Was your child born early, or did they need special care after birth?	◯	◯
8.	Does your child bruise easily, or bleed for a long time after a cut?	◯	◯
9.	Has your child ever had rheumatic fever, a heart murmur or heart surgery?	◯	◯
10.	Does your child snore, or breathe through their mouth?	◯	◯
11.	Has your child ever had a general anesthetic? Any problems? _____	◯	◯
12.	Is there a learning, developmental or behavioural condition we should know about?	◯	◯
	If yes, please tell us more: _____		

13. Does your child have, or have they ever had, any of the following?

☐ ADHD	☐ Asthma	☐ Autism spectrum	☐ Bleeding disorder	☐ Cancer
☐ Diabetes	☐ Eczema	☐ Epilepsy or seizures	☐ Hearing difficulty	☐ Heart condition
☐ Hepatitis	☐ Kidney disease	☐ Liver disease	☐ Speech difficulty	☐ Thyroid problem

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Child's name _____

YOUR CHILD'S DENTAL HISTORY

		YES	NO
1.	Reason for this visit: ☐ Check-up ☐ Emergency ☐ Other: _____		
2.	Has your child been to a dentist before? If yes, when was the last visit? _____	○	○
3.	Which of these has your child had?		
	☐ Check-up and cleaning ☐ Fluoride varnish ☐ Sealants ☐ Fillings ☐ Extractions		
	☐ Dental X-rays ☐ Freezing ☐ Laughing gas ☐ General anesthetic ☐ Braces or a plate		
4.	Does your child get fluoride toothpaste, drops or tablets? Which? _____	○	○
5.	Who brushes your child's teeth? ○ Child alone ○ Child with help ○ Parent or guardian Times a day: _____		
6.	Does your child floss? How often? _____	○	○
7.	Anything to eat or drink other than water after brushing at bedtime? What? _____	○	○
8.	Does your child suck a thumb, fingers or a soother? Until what age? _____	○	○
9.	Did your child take a bottle to bed? What was in it? _____	○	○
10.	Does your child grind or clench their teeth? _____	○	○
11.	Has your child ever injured a tooth, the mouth or the jaw? _____	○	○
	If yes, what happened, and when? _____		
12.	Has your child complained of toothache or a sensitive tooth? Which tooth? _____	○	○
13.	How has your child managed at past appointments? ○ Fine ○ A little nervous ○ Very upset ○ Has not been before		
	What helps your child feel at ease? _____		
14.	Anything else we should know about your child?		

_____

_____

OFFICE POLICY

- To plan the treatment that is best for your overall dental health, we must first make a careful diagnosis. That means a thorough examination, using the fewest X-rays needed for an accurate result.
- We pledge to provide high-quality dentistry as comfortably as possible, with up-to-date equipment, materials and techniques.
- Your appointment time is reserved for you. If you cannot keep it, we need 24 hours' notice; otherwise we will charge for the time lost.
- Our policy is that services are paid for at each visit, as they are performed. In some circumstances a payment arrangement can be made with the dentist or the office manager.
- **Insurance.** Every patient with dental insurance is responsible for paying their own account. We can bill your insurer directly if your plan allows it. Please make sure you understand the limits of your dental plan; we will gladly send in estimate forms if needed.
- A good relationship between dentist and patient rests on mutual respect and understanding. Please feel free to talk to us about any part of your treatment or fees, at any time.

PARENT OR GUARDIAN CERTIFICATION AND CONSENT

To be signed by the patient's parent or legal guardian.

I am the parent or legal guardian of the child named on this form. I certify that the medical and dental information above is true to the best of my knowledge, and that I have not left out anything relevant. I consent to the dental and oral procedures agreed to be necessary or advisable, and I accept responsibility for the fees for these procedures.

DATE _____ SIGNATURE OF PARENT OR GUARDIAN _____

NAME OF PARENT OR GUARDIAN, PRINTED _____ RELATIONSHIP TO THE CHILD _____

This form holds personal health information. All Care Dental keeps it confidential and uses it to care for your child and, when you ask us to, to send claims to your insurer. Please hand it in at the office rather than emailing it.