Promenade Dental Office

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell us about your child

TODAY'S DATE: / / (dd mm yy)

CHILD'S NAME:

NICKNAME: ☐ MALE ☐ FEMALE

CHILD'S BIRTH DATE: / / (dd mm yy) CHILD'S AGE:

SCHOOL: GRADE:

CHILD'S HOME #: SIN #:

CHILD'S HOME ADDRESS:

CITY PROVINCE POSTAL CODE

2 Who is accompanying the child today?

NAME: RELATION:

DO YOU HAVE LEGAL CUSTODY OF THIS CHILD? ☐ YES ☐ NO

WHOM MAY WE THANK FOR REFERRING YOU?

OTHER FAMILY MEMBERS SEEN BY US:

PREVIOUS / PRESENT DENTIST:
(PLEASE CIRCLE ONE)

LAST VISIT DATE: / / (dd mm yy)

PARENT'S MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

3 Mother's Information

NAME: ☐ STEPMOTHER ☐ GUARDIAN

BIRTH DATE: / / (dd mm yy) SIN #:

BUS #: EXT. #: HM #:

EMPLOYER: OTHER #:

Father's Information

NAME: ☐ STEPFATHER ☐ GUARDIAN

BIRTH DATE: / / (dd mm yy) SIN #:

BUS #: EXT. #: HM #:

EMPLOYER: OTHER #:

4 Person Responsible For Account

NAME: RELATION:

BILLING ADDRESS:
STREET/APT. # CITY PROVINCE POSTAL CODE

BUS #: EXT. #: HM #: DL #: SIN #:

5 Dental Insurance

Primary Dental Insurance

INSURANCE COMPANY NAME:

POLICY / GROUP #: DIVISION #:

CERTIFICATE / ID #:

INSURED'S NAME: RELATION TO PATIENT:

INSURED'S BIRTH DATE: / / (dd mm yy)

INSURED'S EMPLOYER:

ORTHODONTIC COVERAGE? ☐ YES ☐ NO

Secondary Dental Insurance

INSURANCE COMPANY NAME:

POLICY / GROUP #: DIVISION #:

CERTIFICATE / ID #:

INSURED'S NAME: RELATION TO PATIENT:

INSURED'S BIRTH DATE: / / (dd mm yy)

INSURED'S EMPLOYER:

ORTHODONTIC COVERAGE? ☐ YES ☐ NO

6 Why did you bring your child to the dentist today?

HAS THE CHILD EVER HAD A SERIOUS PROBLEM ASSOCIATED WITH PREVIOUS DENTAL WORK? ☐ YES ☐ NO

PLEASE EXPLAIN:

IS THE CHILD'S WATER FLUORIDATED? ☐ YES ☐ NO

IS THE CHILD TAKING FLUORIDATED SUPPLEMENTS? ☐ YES ☐ NO

HAS THE CHILD EVER HAD ANY PAIN / TENDERNESS IN HIS / HER JAW JOINT (TMJ / TMD)? ☐ YES ☐ NO

DOES THE CHILD BRUSH HIS / HER TEETH DAILY? ☐ YES ☐ NO

DOES THE CHILD FLOSS HIS / HER TEETH DAILY? ☐ YES ☐ NO

CHILD'S PHYSICIAN:

PHONE #: DATE OF LAST VISIT: / / (dd mm yy)

IS THE CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO

PLEASE DESCRIBE THE CHILD'S CURRENT PHYSICAL HEALTH:

☐ GOOD ☐ FAIR ☐ POOR

PLEASE LIST ALL MEDICATIONS THAT THE CHILD IS CURRENTLY TAKING:

7 Has the child had any of the following medical problems?

please circle Y or N and underline those that apply to your child:

Y N	ANEMIA / RADIATION TREATMENT	Y N	HEART SURGERY / PACEMAKER
Y N	ARTIFICIAL BONES / JOINTS	Y N	HEMOPHILIA / BLEEDING
Y N	ARTIFICIAL VALVES	Y N	HEPATITIS
Y N	ASTHMA / ARTHRITIS	Y N	HIGH / LOW BLOOD PRESSURE
Y N	BLOOD TRANSFUSION	Y N	HIV+ / AIDS
Y N	CANCER / CHEMOTHERAPY	Y N	HOSPITALIZED FOR ANY REASON
Y N	CONGENITAL HEART DEFECT	Y N	KIDNEY PROBLEMS
Y N	DIABETES / TUBERCULOSIS (TB)	Y N	MITRAL VALVE PROLAPSE
Y N	DIFFICULTY BREATHING	Y N	PSYCHIATRIC PROBLEMS
Y N	DRUG / ALCOHOL ABUSE	Y N	RHEUMATIC / SCARLET FEVER
Y N	EMPHYSEMA / GLAUCOMA	Y N	SEVERE / FREQUENT HEADACHE
Y N	EPILEPSY / SEIZURES / FAINTING	Y N	SHINGLES
Y N	FEVER BLISTERS / HERPES	Y N	SINUS PROBLEMS
Y N	HEART ATTACK / STROKE	Y N	ULCERS / COLITIS
Y N	HEART MURMUR	Y N	VENEREAL DISEASE

PLEASE LIST ANY OTHER MEDICAL CONDITION(S) THAT THE CHILD HAS EVER HAD:

Is the child allergic to any of the following?

please circle Y or N and underline those that apply to you:

Y N	ASPIRIN	Y N	ERYTHROMYCIN	Y N	TETRACYCLINE
Y N	CODEINE	Y N	LATEX	Y N	SULPHA
Y N	PENICILLIN	Y N	JEWELLERY/METALS	Y N	DENTAL ANAESTHETICS

LIST ANY OTHER DRUGS / MATERIALS THAT THE CHILD IS ALLERGIC TO:

8 Does the child have any of the following habits?

please circle Y or N and underline those that apply to your child:

Y N	LIP SUCKING / BITING	Y N	NURSING BOTTLE HABITS
Y N	NAIL BITING	Y N	THUMB / FINGER SUCKING

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services that my child may need. **THE PARENT OR GUARDIAN WHO ACCOMPANIES THE CHILD IS RESPONSIBLE FOR PAYMENT AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.**

SIGNATURE DATE (dd/mm/yy)

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help. Our office is committed to meeting or exceeding the standards of infection control mandated by the Canadian Dental Association.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with patient named herein. Initials: Date: / / (dd mm yy)

DOCTOR'S COMMENTS:

1. DATE: / / (dd mm yy) COMMENTS: SIGNATURE:

2. DATE: / / (dd mm yy) COMMENTS: SIGNATURE:

3. DATE: / / (dd mm yy) COMMENTS: SIGNATURE: