

# Child Teen



# Pine Ridge Dental Centre

## Welcome

We would like to welcome you and your child to Pine Ridge Dental Centre. In an effort to provide the best service possible, we ask that you fill out this form. Thank you for your cooperation.

### Patient Information – Child or Teen

Patient's Name (First) \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Nickname (if preferred) \_\_\_\_\_  Male  Female

Patient's Home Phone \_\_\_\_\_ Patient's Home Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Who is filling out this form? Name (First) \_\_\_\_\_ Middle \_\_\_\_\_ Last: \_\_\_\_\_

Relationship \_\_\_\_\_ Do you have medical custody?  Yes  No

Patient's Previous Dentist \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Have we treated another member of your family?  Yes  No

If Yes, Name (First) \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Names and ages of child's brothers and sisters \_\_\_\_\_

### Parents' Information

Name of person responsible for account \_\_\_\_\_

#### Father

Father  Step Father  Guardian

Name (First) \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address (if different from child's) \_\_\_\_\_

Birth Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

If you have insurance coverage for the child, please fill out.

Insurance Company Name \_\_\_\_\_ Group or plan # \_\_\_\_\_ Cert# \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_ Insurance Company Address \_\_\_\_\_

#### Mother

Mother  Step Mother  Guardian

Name (First) \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address (if different from child's) \_\_\_\_\_

Birth Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

If you have insurance coverage for the child, please fill out.

Insurance Company Name \_\_\_\_\_ Group or plan # \_\_\_\_\_ Cert# \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_ Insurance Company Address \_\_\_\_\_

## Medical History

Is the child currently under the care of a physician?  Yes  No

If yes, give details \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Has the child had a major illness or been hospitalized?  Yes  No If yes, give details \_\_\_\_\_

Does the child take any medication?  Yes  No If yes, please list drug \_\_\_\_\_ dose/amount \_\_\_\_\_

Any sensitivities or allergies to food or drugs?  Yes  No

If yes, give details \_\_\_\_\_

## Has the child been treated for any of the following?

- |   |   |   |  |   |
|---|---|---|--|---|
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Blood disorder     | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Heart condition     | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Nervous disorder    | <input type="checkbox"/> Measles        |
| <input type="checkbox"/> Mumps              | <input type="checkbox"/> Chicken pox        | <input type="checkbox"/> Scarlet fever      | <input type="checkbox"/> Strep throat        | <input type="checkbox"/> Tonsillitis    |
| <input type="checkbox"/> Ear aches          | <input type="checkbox"/> Hay fever          | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Lung disease   |
| <input type="checkbox"/> Fainting spells    | <input type="checkbox"/> Ankle swelling     | <input type="checkbox"/> Chest pains        | <input type="checkbox"/> Rheumatic fever     | <input type="checkbox"/> Bruise easily  |
| <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Blood disease      | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Liver disease      | <input type="checkbox"/> Hepatitis A B C D  | <input type="checkbox"/> Psychiatric care   | <input type="checkbox"/> Other major disease |   |

## Dental History

Has the child had previous dental care?  Yes  No

If so, how long ago? \_\_\_\_\_

Has the child ever had orthodontic treatment?  Yes  No

Give details \_\_\_\_\_

Does the child require antibiotics before dental treatment?  Yes  No

If yes, please explain \_\_\_\_\_

Have the adenoids or tonsils been removed?  Yes  No

Have you been informed of any missing or extra permanent teeth?  Yes  No

Has the child ever been treated with decay preventing fluoride?  Yes  No

Have there been any injuries to the child's face, mouth or chin?  Yes  No

Has the child ever had pain or tenderness in the jaw joints (TMJ)  Yes  No

Has the child had an unfavorable reaction at any previous medical or dental care?  Yes  No

## Does/did the child have any of the following habits:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Grinding teeth          | <input type="checkbox"/> Finger/thumb sucking | <input type="checkbox"/> Prolonged bottle/pacifier |
| <input type="checkbox"/> Chewing/eating problems | <input type="checkbox"/> Mouth breather       | <input type="checkbox"/> Speech problems           |
| <input type="checkbox"/> Tongue thrusting        | <input type="checkbox"/> Lip biting           | <input type="checkbox"/> Nail biting               |

Is there a family history of:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> High decay rate | <input type="checkbox"/> Extra Teeth     | <input type="checkbox"/> Gum disease   |
| <input type="checkbox"/> Missing teeth   | <input type="checkbox"/> Malformed teeth | <input type="checkbox"/> Crooked teeth |

How often does your child brush? \_\_\_\_\_ Floss? \_\_\_\_\_

Additional information \_\_\_\_\_

## Signature

I understand that the information that I have provided is correct to the best of my knowledge and that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination of the child by the doctor, dental treatment that is necessary or advised and the use of local anesthetic or relative anesthesia. I accept responsibility for the fees associated with treatment. I understand that payment is due when services are rendered. Alternate payment arrangements must be made in advance of treatment. Payment methods include VISA, MasterCard, Direct Debit, and cash.

Signature \_\_\_\_\_ Date \_\_\_\_\_