Welcome! *To help us meet your child's dental needs, kindly complete the following confidential information*

CHILD INFORMATION

Child's Name: _____ Date of Birth: D/_____M/_____YR/_____

Male Female Age: _____School: _____ Grade: _____

Mailing Address: : _____ City: _____ Prov: ___ PC: _____

Parent's Email: _____

WHOM MAY WE THANK FOR YOUR REFERRAL: _____

Mother's Name: _____ Father's Name: _____

Mother's Date of Birth: _____ Father's Date of Birth: _____

Mother's Mobile Phone: _____ Father's Mobile Phone: _____

APPOINTMENT POLICY: Our office requests a **minimum of 48 hours** advance notice to cancel or make changes to your reserved appointment. This advance notice allows us to schedule another patient who has been waiting to see us. A fee may be applied to your account if you fail to provide notice. We thank you for your cooperation and consideration.

DENTAL INSURANCE: **Kindly provide your Insurance card to our friendly administrator

Direct Billing to Insurance benefits is a courtesy we offer our patients. Patient portions are due at the time of treatment. In order to 'Direct Bill' your insurance we ask that a credit card be kept on file for any amount not paid by your benefits or any unforeseen balances. Accounts not paid at the time of visit are due no later than 7 days after first statement. Outstanding accounts over 45 days will be charged 5% interest monthly. I hereby agree to the Financial Policy of Didsbury Dental Centre as outlined above and authorize Didsbury Dental Centre to apply any outstanding balance on my account, not covered by my insurance provider, to the credit card listed below:

Circle Payment Option: VISA Master Card

Card #: _____ Expiry Date: _____ CC Security Code: _____

Card Holder's Name: _____ Authorized Signature: _____

MEDICAL HEALTH HISTORY

Name of your child's Physician: _____

DOES YOUR CHILD HAVE OR EVER HAD? Please check yes or no:

Yes	No		Yes	No	
		Anemia			Heart Disease
		Arthritis			Heart Murmur
		Artificial Joints			Hepatitis
		Asthma			HIV/AIDS/A.R.C.
		Blood Disease			Kidney Disease
		Diabetes			Liver Disease
		Dizziness			Handicaps/Disabilities
		Epilepsy/Seizures			Rheumatic or Scarlet Fever
		Excessive Bleeding			Sinus Problems
		Fainting			Stomach Problems
		Glaucoma			Stroke
		Head Injury			Tuberculosis

HAS YOUR CHILD EVER HAD AN ALLERGIC REACTION TO THE FOLLOWING? Please check yes or no:

Yes	No	
		Local Anesthetic (Freezing)
		Penicillin or other Antibiotics
		Codeine, Demerol or other narcotics
		Metals
		Latex

Please list any current medications, vitamins or supplements, or other medical conditions not listed.

_____

_____

DENTAL HISTORY

Please check yes or no to the following questions.

Yes	No		
		Does your child have any dental problems?	If yes, please explain: _____
		Has your child been to the dentist before?	If yes, date of last visit: _____
		Has your child ever had a serious/difficult problem associated with dental work?	If yes, explain: _____
		Does your child have a finger or thumb habit?	If yes, how long: _____
		Has your child ever had an injury to the face or jaw?	If yes, explain: _____
		Are you happy with the appearance of your child's teeth?	If no, explain: _____

How often does your child brush? _____ How often does your child floss? _____

I understand that the information that I have give is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent/Guardian: _____ Date: _____