WINNIPEG PEDIATRIC DENTISTS

1. CHILD'S NAME _____ Today's Date _____
Father's Name _____ Occupation _____
Address _____ City/Town _____ Postal Code _____
Home Ph# _____ Work Ph# _____ Cell Ph# _____
Employed by _____
Mother's Name _____ Occupation _____
Address _____ City/Town _____ Postal Code _____
Home Ph# _____ Work Ph# _____ Cell Ph# _____
Employed by _____
Guardian _____

Physician or Paediatrician _____ MHSC # _____
Family Dentist _____ PHIN # _____
Do you have Dental Insurance? Yes ❑ No ❑
Insurance Co. _____ Policy# _____ Grp.# _____
Do you have any <u>other</u> form of dental coverage? Yes ❑ No ❑
Insurance Co. _____ Policy# _____ Grp.# _____
Name of Person responsible for Account _____
Whom may we thank for refering you? _____

2. CHILD'S HISTORY
Name _____ Sex M _____ F _____ Usually called _____
Age _____ Date of Birth _____ Place of Birth _____
School _____ Grade _____

Do you consider your child to be (check one)	Yes	No
Progressing Normally	❑	❑
Developmentally delayed	❑	❑

Brother's & Sister's Names & Ages _____

3. MEDICAL HISTORY

	Yes	No
Is your child now under the care of a physician for other than routine visits?	❑	❑
If yes, explain. _____		
Has your child ever had any serious illness, handicap or been hospitalized?	❑	❑
If yes, explain. _____		
Does your child have nose bleeds or bruise easily?	❑	❑
If yes, explain. _____		
Did mother have any problems during pregnancy or delivery?	❑	❑
If yes, explain. _____		
Child's Birth weight _____		
Were there any problems at birth or shortly after?	❑	❑
_____		
Is your child now taking any medication?	❑	❑
If yes, list names and dosage of drug(s) _____		
Does your child have any allergies?	❑	❑
If yes, list types of allergies _____		

Has your child had any of the following Conditions?

Rheumatic Fever	❑	Convulsions	❑	Drug Allergies	❑
Heart Troubles	❑	Nervous Disorders	❑	Asthma/Hay Fever	❑
Epilepsy	❑	Lung Problems	❑	Mental Disorders	❑
Diabetes	❑	Jaundice	❑	Strep Throat	❑
Blood Disorders	❑	Liver Problems	❑	Operations	❑
Seizures	❑	Kidney Problems	❑	Bruise Easily	❑

Further Description (if any) _____

_____

Is your child now taking or has ever taken:

Penicillin	❑	Cortisone	❑	Other Antibiotics	❑
Local Anaesthetic	❑	Other Drugs	❑	General Anaesthetic	❑

Has your child had any unfavourable reaction to these drugs? _____

4. DENTAL HISTORY

Are you seeking routine dental care? Yes ❑ No ❑

Does your child have any of the following dental problems?

❑ Cavities
❑ Toothaches
❑ Teeth sensitive to sweet
❑ Crooked teeth
❑ Other dental problems. _____
❑ Teeth sensitive to hot or cold
❑ Gum Infections
❑ Teeth bumped or broken
❑ Abnormal color of teeth

Do you feel your child will be an uncooperative dental patient? Yes ❑ No ❑

Has you child had previous dental care? _____ If so, how did your child react to his/her dental treatment?

_____

How often does your child brush and floss his/her teeth? _____

Do you supervise your child while brushing and flossing? _____

Does your child suck his/her thumb, finger, soother, ect. If so, how often? _____

5. DIETARY HISTORY

Was your child bottle fed? _____ If yes, at what age was it stopped? _____

Was your child breast fed? _____ If yes, at what age was it stopped? _____

Does your child have between-meal snacks? _____

Does your child have bed-time snacks? _____

Has the dentist ever explained to you the importance of a proper diet in the growth and development of sound, healthy teeth?

_____

Do you give your child any form of fluoride? _____

6. PARENT'S CONSENT

I hereby consent to the performing of dental procedures for my child, including radiographs, local anaesthesia, and all other proper and acceptable methods to complete these procedures and I accept responsibility for the fee after treatment plan cost has been discussed. I authorize the transfer of my child's x-rays to a dentist that may request them for the dental treatment of my child. I release you from all legal responsibility that may arise from this authorization.

Date _____ Parent's Signature _____