Vellore Corners **DENTISTRY**
FAMILY & COSMETIC DENTAL CARE

Welcome

to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Patient# _____

Date _____

Your Child

Child's Name _____ Nickname _____

Birthdate _____ Age _____ Sex _____

SIN _____

School _____ Grade _____

Child's Home Address _____ City _____ Prov. _____ P.C. _____

Phone _____

Responsible Party

Name _____ Relationship _____

Address _____

Email _____ City _____ Prov. _____ P.C. _____

Drivers License # _____ SIN# _____

Who is Responsible For Making Appointments?

Name _____ Best Time to Call _____

Home Phone _____ Cell Phone _____ Time _____ Day _____

Work Phone _____ Ext _____

Mother ❑ Stepmother ❑ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext _____

Email _____

Employer _____

SIN _____ DL# _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Father ❑ Stepfather ❑ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext _____

Email _____

Employer _____

SIN _____ DL# _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Insurance

Do you have Dental Insurance? ❑ Yes ❑ No

Insurance Company _____ Group# _____ Policy ID# _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer: Payment in full at each appointment.

❑ Cash ❑ Personal Cheque Credit Card ❑ Visa ❑ Mastercard ❑ I wish to discuss the office's payment policy

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Dental and Health History (confidential)

Patient ID _____

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

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

Is your child's water fluoridated? ..... ❑ Yes ❑ No Does your child take fluoride supplements? ..... ❑ Yes ❑ No

Does your child:

Suck thumb/finger? ..... ❑ Yes ❑ No Chew hard objects (pencils, etc.) ..... ❑ Yes ❑ No

Suck/Bite lip? ..... ❑ Yes ❑ No Grind teeth ..... ❑ Yes ❑ No

Bite/Chew nails? ..... ❑ Yes ❑ No Clench jaw ..... ❑ Yes ❑ No

Previous Dentist? _____ Address _____

Date of last dental visit? _____

Has your child had difficulty with previous dental visits? ..... ❑ Yes ❑ No

Child's Physician _____ Address _____

Phone _____

Previous Hospitalizations/Surgeries/Serious Illnesses? _____ When? _____

_____ _____

Is your child taking medication? ..... ❑ Yes ❑ No (if yes, please list)

_____

Has your child ever taken Fen/Phen Redux? ..... ❑ Yes ❑ No

_____

Does you child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocaine, etc.)?
❑ Yes ❑ No (if yes, please describe)

_____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)?

_____

Has your child ever had any of the following:

Asthma ..... ❑ Yes ❑ No
Cancer ..... ❑ Yes ❑ No
Hepatitis ..... ❑ Yes ❑ No
HIV/AIDS ..... ❑ Yes ❑ No
Hemophilia ..... ❑ Yes ❑ No
A persistent cough or throat clearing not associated with a know illness (lasting more than 3 weeks) ..... ❑ Yes ❑ No
Abnormal bleeding ..... ❑ Yes ❑ No
Stomach, liver or kidney problems ..... ❑ Yes ❑ No
Handicaps/Disabilities ..... ❑ Yes ❑ No
Tuberculosis ..... ❑ Yes ❑ No
Diabetes ..... ❑ Yes ❑ No
Rheumatic Fever ..... ❑ Yes ❑ No
Congenital Heart Defect ..... ❑ Yes ❑ No
Heart Murmur ..... ❑ Yes ❑ No
Convulsions/Epilepsy ..... ❑ Yes ❑ No

Please explain any medical problems your child has: _____

_____

_____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor) _____ Date _____

Doctor's comments _____

_____

Signature _____ Date _____