Gateway Pediatric Dentistry Medical and Dental History

Date:_____ Patient Name:(Last)_____(First)_____(Preferred)_____

Birth date (DD/MM/YYYY): _____ □ Male □ Female □ Other: _____

Name of person completing this form: _____

Relationship to patient: □ Parent □ Guardian □ Other:_____

Mother/Father's name: _____ Mother/Father's name:_____

Home address:_____ City_____

Province_____ Postal Code: _____ Child's Alberta Health Care#: _____

EMAIL Address: _____ Physician: _____

Mobile Phone Number:_____ Alternate Phone Number :_____

Dental Insurance

Policy Holder Name: _____
Insurance Co. Name_____
Group/Policy Number: _____
ID#_____
Date of Birth: (DD/MM/YY) _____

Policy Holder Name: _____
Insurance Co. Name: _____
Group/Policy Number: _____
ID#_____
Date of Birth: (DD/MM/YY) _____

Were you referred to our office? □ Yes □ No If yes, by whom? _____

Do you have any special family circumstances, privacy requests or insurance policy concerns we should be aware of? □ Yes □ No Please describe_____

MEDICAL HISTORY

□ Yes □ No Is your child in good health? Date of last medical exam _____
□ Yes □ No Has your child ever had a health problem? _____
□ Yes □ No Is your child allergic to anything? _____
□ Yes □ No Is your child currently taking any medications? If yes, please provide medication, dose and reason:_____
□ Yes □ No Are your child's immunizations current? _____
□ Yes □ No Have you ever been told that your child needs to take antibiotics before dental treatment?
□ Yes □ No Has your child ever been hospitalized, had general anesthesia, or emergency room visits?
□ Yes □ No Were there any difficulties at birth or pre-mature?_____

Please check if your child has been treated for any of the following:

□ Heart disease	□ Heart murmur	□ Bleeding/transfusions	□ Asthma
□ Anemia	□ Blood disorders	□ Tonsil/adenoid problems	□ Tuberculosis
□ Liver Disease	□ Sickle cell disease	□ Diabetes	□ HIV/AIDS
□ Kidney disease	□ _____Syndrome	□ Hepatitis	□ Mental delays
□ Speech/hearing	□ Seizures	□ Cleft lip/palate	□ Physical delays
□ Eyesight	□ Congenital birth defects	□ Gastric disease / Reflux	□ Cancer/Tumors
□ Cerebral palsy	□ Significant injuries	□ Endocrine/growth	□ Autism
□ Arthritis	□ ADHD	□ Spina bifida	□ Snoring

Other:_____

Dental History

What is the reason for your child's dental visit?_____

□ Yes □ No Has your child ever been to the dentist? Date of last cleaning & x-rays(if taken)_____

□ Yes □ No Has your child experienced any unfavourable reaction from previous dental care?
Explain_____

□ Yes □ No Does your child suck a finger, thumb, or pacifier?

□ Yes □ No Does your child have pain with chewing, or while sleeping?

□ Yes □ No Does your child go to bed with a bottle or sippy cup?

□ Yes □ No Does your child snack frequently? Favourite snack foods? _____

□ Yes □ No Has your child had local anesthetic? Were there any problems?_____

□ Yes □ No Has your child been sedated for dental treatment? Were there any problems?_____

□ Yes □ No Have your child's teeth ever been injured? Which teeth?_____
Dental treatment for trauma:_____

Please check if your child is having problems with any of the following:

□ Cavities	□ Toothache	□ Sensitive teeth	□ Mouth breathing
□ Trauma	□ Gum Infections	□ Color of Teeth	□ Other
□ Orthodontics	□ Jaw Sounds	□ Grinding of Teeth	

Comments:_____

Consent for Dental Treatment

As the parent and/or legal guardian of the patient, I do hereby request and authorize Drs. Richard Graham, Adam Palmer, Maria Ray, Brian Lam, Simrit Nijjar, Arash Goshtasby and/or Jessica Holownia and staff to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behaviour by helping them understand the treatment in terms appropriate for their age. Drs. Graham, Lam, Palmer, Ray, Nijjar, Goshtasby and/or Holownia will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Gateway Pediatric Dentistry of any changes in my child's medical status.

Legal Guardian's Signature: _____ **Date:** _____