

Gateway Pediatric Dentistry Medical and Dental History

Date: _____ Patient Name: _____

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

Name of person completing this form: _____

Relationship to patient: Parent Guardian Other: _____

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

Home address: _____ City: _____

Province _____ Postal Code: _____ Phone Number _____

Email address: _____ Alternate Phone _____

Child's Alberta Health Care #: _____ Physician: _____

Dental Insurance (Mother)

Dental Insurance (Father)

Insurance Co. Name: _____

Insurance Co. Name: _____

Employer Name: _____

Employer Name: _____

Group/Policy Number: _____

Group/Policy Number: _____

Employees Certificate # _____/ID# _____

Employees Certificate # _____/ID# _____

Date of Birth: (DD/MM/YY) _____

Date of Birth: (DD/MM/YY) _____

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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Bleeding/transfusions | <input type="checkbox"/> Asthma/breathing |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Tonsil/adenoid problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sickle cell disease/trait | <input type="checkbox"/> Diabetes | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental delays |
| <input type="checkbox"/> Speech/hearing | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Physical delays |
| <input type="checkbox"/> Eyesight | <input type="checkbox"/> Congenital birth defects | <input type="checkbox"/> Gastric disease / reflux | <input type="checkbox"/> Cancer/tumors |
| <input type="checkbox"/> Recurrent headaches | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Adverse drug reactions | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Significant injuries | <input type="checkbox"/> Endocrine/growth | <input type="checkbox"/> Autism | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Spina bifida | <input type="checkbox"/> Snoring | <input type="checkbox"/> Abuse |

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) _____
Name of previous /referring dentist: _____ Phone: _____
- 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:

- | | | | |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Toothache | <input type="checkbox"/> Sensitive teeth | <input type="checkbox"/> Mouth breathing |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Gum Infections | <input type="checkbox"/> Color of Teeth | <input type="checkbox"/> Other |
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Jaw Sounds | <input type="checkbox"/> Grinding of Teeth | |

Comments: _____

Consent for Dental Treatment

As the parent and/or legal guardian of the patient, I do hereby request and authorize Dr. Maria Ray/Richard Graham 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' Ray/Graham 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:** _____

Doctor Signature: _____ **Date:** _____