RELIANCE DENTAL

Child Registration Form

Welcome to our office! Thank you for taking the time to fill out these important documents. We look forward to getting to know you better!

PATIENT NAME: _____

DATE OF BIRTH (Day/Month/Year): _____ M ☐ F ☐

ADDRESS: _____POSTAL CODE: _____

RESIDENCE PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ OCCUPATION: _____

EMAIL ADDRESS: _____ ☐ I consent to having email/reminders sent to me

PATIENT'S PARENTS/GUARDIAN/OR SPOUSE: _____

DATE OF BIRTH(Day/Month/Year): _____ PHONE NUMBER: _____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY: NAME: _____

RELATIONSHIP: _____ PHONE: _____

NAME OF DOCTOR: _____ PHONE: _____

NAME OF INSURANCE COMPANY (IF APPLICABLE): _____

How did you hear about our office? Check all that apply. FLYER ☐ LOCATION ☐ WEBSITE ☐

BILLBOARD ☐ REFERRAL ☐ (By whom) _____

- Due to privacy and confidentiality matters insurance companies provide dental providers with little information. Please be prepared and/or aware of your dental coverage, as it is the ***PERSONAL RESPOSIBILITY OF THE PATIENT***. **Any portion not covered by your plan is *YOUR* responsibility when the treatment is rendered**. We will help prepare necessary reports to assist you to collect your benefits from insurance companies. A credit card number may be requested to reserve your appointment time. However, our treatment plans are based on individual patient needs and preferences, and not primarily on whether the dental treatment is covered by insurance. **APPOINTMENTS**: Appointment times are reserved for you. If you are unable to keep an appointment, please give us at least 2 business days' notice to make alternate scheduling arrangements, or a cancellation fee may apply.

PRIVACY: I understand that the required standards of personal information confidentiality are being met in accordance with the Health Professionals Act and the Alberta Personal Information Protection Act.

☐ I have read and understand the above conditions and content.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN: _____

DATE: _____

RELIANCE DENTAL

MEDICAL HISTORY QUESTIONAIRE *MEDICAL ALERT* _____

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____
3. Is the child allergic to anything else, such as certain foods? If yes, please explain:

_____

4. How would you describe the child's eating habits?_____
5. Has the child ever had a serious illness? If yes, when: _____
Please describe: _____
6. Has the child ever been hospitalized? If yes, what for? _____
7. Does the child have a history of any other illnesses? If yes, please list:

_____

8. Has the child ever received a general anesthetic? _____
9. Does the child have any inherited problems? _____
10. Does the child have any speech difficulties? _____
11. Has the child ever had a blood transfusion? _____
12. Is the child physically, mentally, or emotionally impaired? _____
13. Does the child experience excessive bleeding? _____
14. Is the child currently being treated for any illnesses? _____
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____
16. Has the child had any problem with dental treatment in the past? _____
17. Has the child ever had dental radiographs (x-rays) exposed? _____
18. Has the child ever suffered any injuries to the mouth, head or teeth? _____
19. Has the child had any problems with the eruption or shedding of teeth? _____
20. Has the child had any orthodontic treatment? _____
21. What type of water does your child drink? _____
22. Does the child take fluoride supplements? _____
23. Is fluoride toothpaste used? _____
24. How many times are the child's teeth brushed per day? _____
25. Does the child suck his/her thumb, fingers or pacifier?_____
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____
27. Does child participate in active recreational activities? _____

PATIENT'S PARENTS/GUARDIAN SIGNATURE_____

DATE _____