Just 4 Kids
Pediatric Dentistry

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Certified Specialist in Pediatric Dentistry

PATIENT INFORMATION

Name : _____
First Middle Initial Last

DOB (DD/MM/YY): _____

Sex: M _____ F _____

Address: _____

City_____ Postal Code _____

Tel (Home): _____

MSP Card # _____

Referred by: ☐Dentist _____

☐ Friend _____

☐Sibling ☐Drive-by/signage ☐Internet

☐ Other (please specify)_____

Family dentist's name: _____

Family doctor's name: _____

Address: _____

Tel: _____

Names of siblings (if applicable)	Age	Patient of this office Yes	No
_____	____	☐	☐
_____	____	☐	☐
_____	____	☐	☐

INSURANCE INFORMATION

☐ None

☐ Health Kids Program

Amount used $_____ as of date _____

☐ Insurance through work (See below)

Primary Policy Holder #1: _____

DOB (DD/MM/YY): _____

Insurance Company: _____

Group No. _____Div.____S.I.N._____

ID No. _____

Employer _____

Annual max. limit: $____/person; $____/family

Recall frequency: ☐6 mos ☐9 mos ☐12 mos

Primary Policy Holder #2: _____

DOB (DD/MM/YY): _____

Insurance Company: _____

Group No. _____Div.____S.I.N._____

ID No. _____

Employer _____

Annual max. limit $____/person; $____/family

Recall frequency: ☐6 mos ☐9 mos ☐12 mos

PARENT/GUARDIAN INFORMATION

Mother/Guardian

Name: _____

DOB (DD/MM/YY): _____

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐Common Law ☐ Widowed ☐ Re-married

Address: ☐ Same as Patient

_____

City_____ Postal Code _____

Tel (H): _____

(W): _____Ext. _____

(C): _____

E-mail: _____

Father/Guardian

Name: _____

DOB (DD/MM/YY): _____

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐Common Law ☐ Widowed ☐ Re-married

Address: ☐ Same as Patient

_____

City_____ Postal Code _____

Tel (H): _____

(W): _____ Ext. _____

(C): _____

E-mail: _____

HEALTH HISTORY	YES	NO
1. Has your child ever had any serious illness? If yes, please explain_____	☐	☐
2. Has your child ever been hospitalized or had an operation? If yes, please explain_____	☐	☐
3. Are your child's immunizations up-to-date?	☐	☐
4. Were there any complications surrounding the pregnancy or birth of your child?	☐	☐
5. Has your child ever had prolonged bleeding following a tooth extraction or minor injury?	☐	☐
6. Has you child ever had general anesthesia before? If yes, when? _____	☐	☐
7. Is your child being treated for any medical condition at the present time or within the past year? If yes, please explain: _____	☐	☐
8. Is your child taking any medication, non-prescription drugs or herbal supplements of any kind? If yes, please list: _____	☐	☐
9. Is your child allergic to any medication (penicillin, pain killers, sulfa drugs, etc.)? _____	☐	☐

10. If your child currently **has** or **has ever had** any of the following, please check off the box (otherwise, please leave blank):

☐ Heart disease	☐ Anemia	☐ Skin disease (e.g. eczema)
☐ Heart attack	☐ Hemophilia	☐ Visual, hearing or sinus problems
☐ Stroke	☐ Blood transfusion	☐ Malignant hyperthemia
☐ Chest pain/angina	☐ Stomach ulcers	☐ Fainting spells
☐ Heart murmur	☐ Kidney disease	☐ Infectious disease
☐ Artificial heart valve	☐ Dialysis therapy	☐ HIV/AIDS
☐ Mitral valve prolapse	☐ Liver disease	☐ Mental disability
☐ Pacemaker	☐ Jaundice	☐ Learning disability
☐ High blood pressure	☐ Hepatitis A, B, or C	☐ Attention Deficit disorder
☐ Shortness of breath	☐ Lung disease	☐ Autism
☐ Rheumatic fever	☐ Asthma	☐ Speech delay
☐ Kawasaki's disease	☐ Bronchitis	☐ Cerebral palsy
☐ Arthritis	☐ Tuberculosis (TB)	☐ Seizure disorder/epilepsy
☐ Prosthetic/artificial joints	☐ Diabetes	☐ Cancer
☐ Sickle cell trait/disease	☐ Thyroid disease	☐ Allergies _____
☐ Bleeding/clotting disorder	☐ Immune deficiencies	☐ Others _____

DENTAL HISTORY	YES	NO
1. What is the primary reason for this appointment? _____		
2. When did your child last see a dentist? _____ Reason for visit _____		
3. Is your child currently experiencing any dental pain? If yes, how long has it been? _____	☐	☐
4. Has your child had an unfavorable dental/medical experience in the past? If yes, please explain: _____	☐	☐
5. How do you expect your child to behave during today's visit? ☐excellent ☐fair ☐ poor		
6. Has your child ever injured his/her teeth or mouth? If yes, please explain: _____	☐	☐
7. Does your child have any oral habits (e.g. digit sucking, pacifier, lip biting, teeth grinding)?	☐	☐
8. Who brushes your child's teeth? ☐ Mom ☐Dad ☐ Him/herself ☐ Other _____ How often? _____ times/day		
9. Does your child use any toothpaste?	☐	☐
10. Does the toothpaste contain fluoride?	☐	☐
11. Does your child use floss? If yes, how often? _____times/week	☐	☐
12. Does your child go to bed with a bottle? If yes, what's in the bottle? _____	☐	☐

I, the undersigned, verify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my physician being contacted if necessary to obtain information that is required for my child's dental care. I authorize the dentist to perform the diagnostic procedures that may be required to determine the necessary treatment and assume financial responsibility for dental services rendered for my child.

Parent/Guardian signature _____ Date _____

Reviewed by dentist _____ Date _____