ATLANTIC DENTAL
Halifax

PATIENT INFORMATION
CHILDREN'S HISTORY

DATE _____

*Your cooperation in filing out the data on the confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with this office.

CHILD'S FULL NAME _____
Last First Middle

AGE _____ SEX _____

ADDRESS _____
Street City Prov. (State) Postal Code (Zip)

HOME PHONE _____ DATE OF BIRTH _____
Day Mo. Year

DENTAL INS. YES NO NAME OF COMPANY _____

INS. POLICY NO. _____ % COVERED _____

MSI No. _____

FAMILY PHYSICIAN _____ PHONE NO. _____

PREVIOUS DENTIST _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IN CASE OF EMERGENCY NOTIFY: NAME _____

ADDRESS _____

RELATIONSHIP _____ TELEPHONE _____

NAME PERSON RESPONSIBLE FOR ACCOUNT: _____

ADDRESS _____
Last First

DRIVER'S LICENSE No. _____

CONFIDENTIAL MEDICAL HISTORY

When did your child last visit a physician? _____

Reason _____

Has your child ever had a serious illness or been in the hospital? _____

If so, describe _____

Does your child have any known medical, physical or mental challenges? _____

If so, describe _____

Has your child ever had any of the following?

- ❑ Measles
- ❑ Kidney Disease
- ❑ Lung Disease
- ❑ Heart Trouble
- ❑ Scarlet Fever
- ❑ Epilepsy
- ❑ Fainting Spells
- ❑ Adenoids
- ❑ Ear Trouble
- ❑ Asthma
- ❑ Mumps
- ❑ Diabetes
- ❑ Tuberculosis
- ❑ Rheumatic Fever
- ❑ Strep. Throat
- ❑ Operations
- ❑ Liver Disease
- ❑ Abnormal Blood Pressure
- ❑ Shortness of Breath
- ❑ Hay Fever
- ❑ Chicken Pox
- ❑ Gland Trouble
- ❑ Nervous Disorder
- ❑ Chest Pains
- ❑ Tonsils
- ❑ Physical Deformity
- ❑ Jaundice
- ❑ Emotional Problems
- ❑ Other

If yes to any of the above, describe _____

_____

(over)

Is your child allergic to anything? _____

If yes, describe _____

Does he or she bruise or bleed profusely for a long period of time, or have any blood disorders? _____

Does your child have a heart murmer or a history of rheumatic fever? _____

Is your child now taking, or has he or she had any medications?

ie: Penicillin _____ Other Antibiotics _____

Local Anaesthesia(freezing) _____ General Anaesthesia(sleeping)_____

Other Drugs _____

Has he or she had any unfavourable reaction to these drugs? _____

Has your child had previous dental care? _____

Has he or she had an unpleasant experience associated with dental treatment? _____

If yes, describe _____

How often does your child brush his or her teeth? _____

Has your child ever received fluoride supplements in the diet or water supply? _____

ADDITIONAL INFORMATION

If there is any specific problem regarding your child's oral health which concerns you, or if there is any additional information which you feel may be helpful in our care of your child, please state below.

_____

_____

_____

CONSENT FOR TREATMENT

I consent to the performing of the dental procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with those procedures. I have reviewed the Privacy Statement for Patients that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see the Code at any time. I agree that Atlantic Dental Centre can collect, use and disclose my personal information as set out in the office's privacy policy.

Parents Signature _____ Date _____

OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise it will be necessary to charge for the time lost.

Office policy is that services are paid for at each visit as they are performed.

Electronic Claims Submission Signature on File (CDAnet)

I authorize release, to my dental benefit plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist.

_____ _____

Signature of Patient or parent/guardian **Date**