Healthy Smiles

NEW PATIENT CHILD

Name _____ (LAST / FIRST / MIDDLE INITIAL(S)) AB Health No. _____

Preferred Name _____ Gender _____ Date of Birth M D Y

Address _____ City _____ Postal Code _____

Phone (H) _____ Phone (C) _____ E-mail _____

Person responsible for account _____ Relationship _____

In case of emergency, contact _____ Phone _____

WHOM MAY WE THANK FOR YOUR REFERRAL ☐ Friend _____

☐ Google ☐ Radio ☐ Website ☐ Other _____

DENTAL HISTORY

What is your immediate concern for your child? _____

Has your child been to the dentist before? ☐ Yes ☐ No
Name of previous dentist _____ Date of last visit _____

Has your child ever had an injury to the teeth, face, or jaw? ☐ Yes ☐ No
If yes, please explain _____

Has your child ever had serious/difficult problems associated with dental work? ☐ Yes ☐ No
If yes, please explain _____

Has your child ever had a negative dental experience or is nervous about the dentist? ☐ Yes ☐ No
If yes, please explain _____

Does your child have a fear of needles? ☐ Yes ☐ No

Are you concerned your child may require sedation for dental treatment? ☐ Yes ☐ No

Does your child have any habits? ☐ Chew fingernails or pens ☐ Suck thumbs or fingers
☐ Pacifier use ☐ Other _____

Are you unhappy with the appearance of your child's teeth? ☐ Yes ☐ No
If yes, please explain _____

Does your child drink anything other than water more than three times daily between meals? ☐ Yes ☐ No
If yes, please specify _____

Does your child have anything other than water after brushing before bedtime? ☐ Yes ☐ No
If yes, please specify _____

Do you use fluoride toothpaste for your child? ☐ Yes ☐ No

How often does your child brush? _____

How often does your child floss? _____

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Phone: 403-986-8000 | Fax: 403-986-8020 | Email: info@dentalhealthysmiles.com
dentalhealthysmiles.com

MEDICAL HISTORY

Physician's Name _____ Phone _____

Has your child been under the care of a medical doctor during the past 2 years? □ Yes □ No
If yes, please explain _____

Has your child ever had an allergic or bad reaction to a drug, medication, or other? □ Yes □ No

□ NSAID □ acetaminophen □ codeine □ antibiotic _____
□ latex □ local anesthetic □ sedatives □ other _____

Has your child been advised to take antibiotics before undergoing dental procedures? □ Yes □ No
Has your child been hospitalized or had a major operation? □ Yes □ No
Is your child up to date on vaccinations? □ Yes □ No

Check if your child has had any of the following, or presently have:

□ Heart disease or attack	□ Stroke	□ Cancer	□ HIV / AIDS
□ Heart surgery	□ Anemia or blood disorder	□ Radiation	□ Venereal disease
□ Congenital heart disease	□ Asthma	□ Chemotherapy	□ Neurological disorders
□ Angina	□ Emphysema or COPD	□ Kidney disease	□ Psychiatric care
□ Infective endocarditis	□ Tuberculosis	□ Hepatitis, jaundice, or liver disease	□ Autism or special needs
□ Artificial heart valve	□ Sinus troubles		□ Nervous disorder
□ Pacemaker	□ Diabetes	□ Stomach or digestive problems (e.g. reflux, ulcers, celiac, bulimia)	□ Fainting or dizzy spells
□ Artificial joint	□ Thyroid disease		□ Epilepsy or seizures
□ Medical implant	□ Arthritis		□ Hearing difficulty
□ High/low blood pressure	□ Autoimmune disease	□ Glaucoma	□ Speech difficulty

Does your child have, or have had, any medical conditions not listed? □ Yes □ No
If yes, please specify _____

Does your child have any current medical treatment, impending surgery, genetic/development delay, or other treatment that may affect your dental treatment? □ Yes □ No
If yes, please explain _____

List any current medications, vitamins, and supplements:

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

TREATMENT CONSENT

I certify that the medical and dental histories provided are accurate and complete to the best of my knowledge. Healthy Smiles may assist with my insurance claims and help provide estimates of costs, but it is my responsibility to understand my dental insurance contract, including coverage and limits. I am responsible for any outstanding amounts owing.

Your appointment times are reserved specially for you. If you are unable to keep your scheduled appointment, **we require a minimum 2 business days notification. Short notice cancellations and no shows are subject to a fee of $100.**

Parent/Guardian Name _____

Parent/Guardian Signature _____ Date _____

Office Signature _____ Date _____