WELCOME TO CHILDREN'S DENTAL WORLD

YOUR CHILD WILL BE SEEING A PEDIATRIC DENTAL SPECIALIST TODAY

Date: _____ (DD / MM / YYYY) ☐ Male ☐ Female

Child's Name: _____ (First) (Middle) (Last)

Date of Birth: _____ (DD / MM / YYYY) Manitoba Health #: __ __ __ __ __ __ (6-Digit Registration #) __ __ __ __ __ __ __ __ __ (9-Digit Identification #)

Mailing Address: _____

City: _____ Prov. _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Emergency Phone: _____

Who accompanied child today? _____ Do you have legal custody of the child? ☐ YES ☐ NO

How did you hear about Children's Dental World?

☐ Dentist _____ ☐ Family/Friend ☐ Radio ☐ Television ☐ Sign

☐ Physician _____ ☐ Newspaper ☐ Internet ☐ Magazine

☐ Other (Please Specify) _____

PARENTS/GUARDIANS INFORMATION

Name: _____

Marital Status: _____

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

Relationship to child: _____

Lives with child ☐ YES ☐ NO

Mailing Address: _____

Employer: _____

Work Phone: _____

Home Phone: _____

Cellular: _____

E-mail Address: _____

Name: _____

Marital Status: _____

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

Relationship to child: _____

Lives with child ☐ YES ☐ NO

Mailing Address: _____

Employer: _____

Work Phone: _____

Home Phone: _____

Cellular: _____

E-mail Address: _____

INSURANCE INFORMATION

Primary Insurance

Subscriber: _____

Relationship to child:_____

Insurance Company:_____

Policy Group Plan #:_____

Contract ID/Subscriber ID #:_____

Social Assistance #:_____

Secondary Insurance

Subscriber: _____

Relationship to child:_____

Insurance Company:_____

Policy Group Plan #:_____

Contract ID/Subscriber ID #:_____

Treaty #:_____

I authorize release to my insuring company information contained in claims submitted electronically on my behalf.

_____
Signature of Parent/Guardian

I hereby assign my benefits payable from claims submitted electronically to Children's Dental World and authorize payment to be received directly with the understanding that any unpaid balance is my responsibility.

_____
Signature of Parent/Guardian

PLEASE CONTINUE TO SECOND PAGE

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DENTAL HISTORY

Why did you bring your child to us today? _____

Is this your child's first visit to the dentist? ☐ YES ☐ NO

If no: Previous Dentist: _____

Date of last visit: _____ Were any x-rays taken? ☐ YES ☐ NO

Has your child had any problems with previous dental care? _____

How do you expect your child to cooperate for dental treatment? _____

Does your child currently have a toothache? ☐ YES ☐ NO

Have there been any injuries to your child's teeth? ☐ YES ☐ NO

If yes, explain: _____

Is the water your child drinks fluoridated? ☐ YES ☐ NO ☐ DON'T KNOW

How often are your child's teeth being brushed? _____ Flossed? _____ By whom? _____

MEDICAL HISTORY

Name of pediatrician or family physician: _____

Is your child currently taking any medication or drugs? ☐ YES ☐ NO

If yes, state why and list: _____

Has your child ever had a bad reaction to drugs, including antibiotics or local/general anesthetics? ☐ YES ☐ NO

If yes, explain: _____

Has your child ever had surgery or been hospitalized? ☐ YES ☐ NO

If yes, explain: _____

Are antibiotics required prior to dental treatment? ☐ YES ☐ NO

Does your child have or ever been diagnosed with any of the following conditions (please check):

☐ AIDS/HIV	☐ Cancer	☐ Hearing Loss	☐ Seizures
☐ ADD/ADHD	☐ Cerebral Palsy	☐ Heart Disease/Murmur	☐ Sickle Cell Anemia
☐ Allergies	☐ Cleft Lip/Palate	☐ Hepatitis	☐ Speech Problems
☐ Anemia	☐ Developmental Delays	☐ Kidney Disease	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ Liver Disease	☐ Other:
☐ Autism	☐ Epilepsy	☐ Mentally Challenged	_____
☐ Bleeding Disorder	☐ Eye Problems	☐ Rheumatic/Scarlet Fever	_____

Details: _____

Is there anything else we should know about your child's health or medical conditions? ☐ YES ☐ NO

If yes, explain: _____

_____

I certify that I have read and understand the above questions. If I had questions about this form, they were answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in completing this form.

I am also aware that if my child has missed or short notice cancelled two or more appointments, it is this clinic's policy that arrangements will need to be made for my child to be seen at a different dental clinic that better accommodates my schedule.

Parent/Guardian Signature: _____ **Date**: _____