New Patient From

Patient Profile *(Please print your child's information below)*

		Today's Date:
First Name:	Last Name:	Middle Name:
Date of Birth (mm/dd/yyyy):		Gender: ☐ Male ☐ Female
Saskatchewan Health Card #:		

Home Address

Street:		City:
Province:	Country:	Postal Code:

Home Phone:	Cell Phone:
Emergency Phone:	Email Address:

Who accompanied the patient today:	Do you have legal custody of the child ☐ Yes ☐ No

Parent/Guardian Profile *(Please Print your information below)*

Contact #1	***Contact #2***
Name:	Name:
Relationship to Patient:	Relationship to Patient:
Date of Birth (mm/dd/yyyy):	Date of Birth (mm/dd/yyyy):
Marital Status:	Marital Status:

Home Address: ☐ *Same as Patient*	*Home Address:* ☐ *Same as Patient*
Street:	Street:
City:	City:
Province:	Province:
Country:	Country:
Postal Code:	Postal Code:

Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Email:	Email:

Do you live with the patient? ☐ Yes ☐ No	Do you live with the patient? ☐ Yes ☐ No
Employer:	Employer:

Insurance Information *(Please Print)*

Primary Insurance

Subscriber:	Relationship to Patient:
Insurance Company:	Policy/Group Plan #:
Contact ID/Subscriber ID #:	
Social Assistance #:	

Secondary Insurance

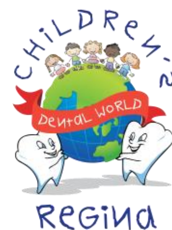
Subscriber:	Relationship to Patient:
Insurance Company:	Policy/Group Plan #:
Contact ID/Subscriber ID #:	
Treaty #:	

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

Signature of Parent/Guardian Date (mm/dd/yyyy)

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

Signature of Parent/Guardian Date (mm/dd/yyyy)



Dental History *(Please Print)*

Why did you bring your child to us today?
Is this your child's first visit to the dentist?

If answer is "No" to first visit:

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 answer is "Yes" to injuries:

Explain:

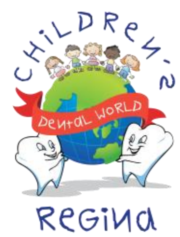
Is the water your child drinks fluoridated?	☐ Yes ☐ No ☐ Don't Know

How often are you child's teeth being:

Brushed:	Flossed:	By Whom?:

How did you hear about us?

- ☐ Referred by dentist ___________________
- ☐ Referred by family/friend
- ☐ Radio Ad
- ☐ T.V Ad
- ☐ Website
- ☐ Social Media
- ☐ Clinic Location
- ☐ Other: ________________________________



Medical History *(Please Print)*

Name of pediatrician or family physician:
Is your child currently taking any medication or drugs? If yes, state what and why:
Has your child ever had a bad reaction to drugs, including antibiotics or local/general anesthetics? If yes, explain:
Has your child ever had surgery or been hospitalized? If yes, explain:
Are antibiotics required prior to dental treatment?

- ☐ Aids/HIV
- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Cleft Lip/Palate
- ☐ Developmental Delays
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Eye Problems
- ☐ Hearing Loss
- ☐ Heart Disease/Murmur
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mentally Challenged
- ☐ Rheumatic/Scarlet Fever
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Speech Problems
- ☐ Tuberculosis
- ☐ Other: ______________________
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Details:
Is there anything else we should know about your child's health or medical conditions? If yes, please 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.

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Signature of Parent/Guardian Date (mm/dd/yyyy)