Patient Information :

Child Full Name:_____ Child Date of Birth: D_____/M_____/Y_____ Gender: M / F

Parent/Guardian Full Name:_____ Parent/Guardian Date of Birth: D_____/M_____/Y_____

Who has legal custody of the child (If applicable):_____

Is the child in foster care? (if applicable): Yes or No

Mailing Address: _____

City/Town:_____Province: _____Postal Code: _____

Telephone #:_____(Home)_____(Business)_____(Cell)_____

Email: _____

NOTE: We now have the capability to do reminder calls by text or email. Please check the appropriate area for which you would like to be contacted.

Email: _____ Text:_____ Telephone:_____

Provincial Health Care #:_____

Family Physician:_____Phone #: _____

Specialist:_____Type:_____Phone#:_____

In case of Emergency, please notify:_____Phone#: _____

Relationship:_____

Medical History:

Is your child in good health? Yes or No
Has your child ever had health problems or been hospitalized? Yes or No
Is your child taking any medications or supplements? _____
_____
Does your child have any allergies? i.e. Medications/food/latex/environmental:_____
_____

Does your child have any of the following?: (Please circle)

Arthritis	Heart Disease/Heart Murmur	Anxiety/Nervousness	Behavior Issues
Asthma	Kidney Disease	Autism (Triggers?)	Psychiatric Issues
Diabetes	Rheumatic Fever	Emotional Disabilities	Infectious Disease
GI Disorder	ADD/ADHD	Learning Disabilities	Bleeding Concerns
Brain Injury	Cerebral Palsy	Cleft Lip/Palate	Developmental Delay
Eating Problem	Seizures	Growth Problems	Speech Problems
Hearing Loss	Neuromuscular Defect	Orthopedic Problems	Cancer/Leukemia

Dental History:

Does your child go to bed with a bottle or sippy cup?: Yes or No

Does your child nail bite?: Yes or No

Does your child suck a thumb/finger/pacifier?: Yes or No

Have you noticed signs of your child clenching/grinding their teeth or biting of their cheek/lip?: Yes or No

Does your child snack frequently?: Yes or No

If yes please list their favourite snack foods/drinks: _____

How often does your child brush their teeth?: _____

Do you assist with brushing your child's teeth?: _____

Do you use floss with your child? _____

Has your child ever been to the dentist? Yes or No

Please supply date of last cleaning and if they had x-rays taken: _____

Has your child had any unfavourable reaction from previous dental care? Yes or No

Please Explain: _____

Would you be interested in treatment with a General Anesthetic or Nitrous Oxide: _____

_____

I _____ have filled out this medical and dental history completely, accurately and to the best of my knowledge. I authorize Gateway Dentistry Group to perform diagnostic procedures necessary to determine treatment needs. I understand there are fees for services rendered and it is my responsibility for payment. I have had the opportunity to ask questions and I consent to treatment.

_____ _____

Signature of Parent/Guardian Witness

_____ _____

Date Date