Dr Nancy Kennedy Dentistry

Limited to Children

Patient/Parent Information

Patient Name: ______________________________ Date of Birth:_____/____/____
Last First YYYY MM DD

Gender: ☐ Male ☐ Female

Mailing Address:____
Street Apartment City Province Postal Code

Parent 1 Name: ______________________ Phone #'s: ______________ ______________
Landline # Mobile #

E-mail Address:______________________________________

Occupation:______________________ Employer Name:______________________

Parent 2 Name: ______________________ Phone #'s: ______________ ______________
Landline # Mobile #

E-mail Address:______________________________________

Occupation:______________________ Employer Name:______________________

Parental Relationship: Married/Commonlaw ☐ Separated/Divorced ☐ Widowed ☐ Single ☐

Patient Health Information

Patient Health Card #: __________________________

Does your child have a regular physician? If yes, please provide doctor's name:	☐ Yes ☐ No
Does your child have an ongoing health problem(s)? If yes, what?_	☐ Yes ☐ No
Is your child under the care of a specialist physician? If yes, since when and why?_ If yes, please provide doctor's name:	☐ Yes ☐ No
Does your child take any medications? If yes what?_	☐ Yes ☐ No
Is your child allergic to penicillin, antibiotics, or other drugs? If yes what?	☐ Yes ☐ No
Is your child allergic or sensitive to latex or any metals? If yes what?	☐ Yes ☐ No
Does your child have any other allergies? If yes what?	☐ Yes ☐ No
Has your child had any serious illness? If yes what? When?	☐ Yes ☐ No
Has your child ever had surgery?	☐ Yes ☐ No
Does your child have a heart murmur?	☐ Yes ☐ No
Does your child experience severe or prolonged bleeding?	☐ Yes ☐ No
Does your child have AIDS/tested positive for HIV?	☐ Yes ☐ No
Has your child tested positive for hepatitis?	☐ Yes ☐ No
Is your child subject to nervous disorders? ☐ Fainting? ☐ Dizziness? ☐ Seizures? ☐ Behavioral/Learning difficulties?	☐ Yes ☐ No
Does your child have frequent headaches/earaches?	☐ Yes ☐ No
Has your child had a history of? (circle appropriate responses) diabetes heart trouble asthma kidney infection rheumatic fever epilepsy cerebral palsy hearing loss vision problems liver problems infections birth defects cancer speech impairments	

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Patient Dental History	
Is this your child's first visit to the dentist? If no, when was the last visit?_	☐ Yes ☐ No
Reason for today's visit?_	
Any history of: ☐ Tooth aches? ☐ Facial Swelling? ☐ Fillings? ☐ Extractions?	
Does your child have any mouth habits? ☐ Thumb sucking? ☐ Tongue thrusting? ☐ Nail biting? ☐ Other:	
Does your child have a fear of the dentist? If yes, why do you think so?_	☐ Yes ☐ No
Is your child uncooperative in Dental or Medical offices?	☐ Yes ☐ No
Has your child had any injuries to his/her teeth?	☐ Yes ☐ No
Has your child ever received a local anesthetic?	☐ Yes ☐ No
Has anyone in the family, including parents, had orthodontics?	☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers provided for health/dental information are true and correct. If my child has any change in health, I understand that it is my responsibility to inform the doctors at future appointments.

Signature ______________________________________ Date: _____/____/____
YYYY MM DD

Insurance Information

Primary (parent whose birthday occurs 1st in the year)

Name of Insured: ____ Insured's Birth Date: _____/___/_____
Last First MI YYYY MM DD

Insurance company__________________________________ Group #__________________________

Id #__________________________ Patient's relationship to insured: ☐ Child ☐ Other

Secondary

Name of Insured: ____ Insured's Birth Date: _____/___/_____
Last First MI YYYY MM DD

Insurance company__________________________________ Group #__________________________

Id #__________________________ Patient's relationship to insured: ☐ Child ☐ Other

How did you hear about our dental practice?

Another patient ☐ Another Dental Office ☐ Yellowpages ☐ Internet ☐ friend/family member ☐ Other ☐

Name of person or dentist referring you to our practice:____

Consent for Services

Because your child is a minor, it is necessary that a signed permission be obtained from a parent or guardian before any necessary dental treatments can be done. The dentist will consult with you about the necessary treatment plan. No treatment will proceed without your agreement. Furthermore, all dental charges hereby incurred for treatment of this child, including examinations, which are not covered by private and/or provincial insurance, will be your responsibility

I have read the above conditions of treatment and consent. I accept the responsibility for the payment of treatment charges that are not covered by private and/or provincial insurance. I understand that I have a right to refuse treatment.

____ Relationship to Patient: __________________
Signature of Parent/Guardian

Date : ____/____/____
YYYY MM DD