sayaka
kids dental care

Patient/Parent/Guardian Information

Child's Information			
Name:	DOB: yyyy/mm/dd	Age:	Sex: M F
Physician:	Siblings (name,age):		
Child's Alberta Health Care #	Have you previously filled out a form for another child? Y N		
Child's School:	If yes, please list:		

Parent #1/Guardian Information			
Name:	DOB: yyyy/mm/dd		
Address:			
Telephone: Home: Work:	Cell:	Email:	
Employer's name:	Occupation:		
Dental Insurance: Company name:	Policy#	ID#	

Parent #2/Guardian Information			
Name:	DOB: yyyy/mm/dd		
Address: Same as above ☐			
Telephone: Home: Work:	Cell:	Email:	
Employer's name:	Occupation:		
Dental Insurance: Company name:	Policy#	ID#	

DENTAL HISTORY

What is the reason for this visit?
If applicable, who referred you to our office:
Last dental visit (when/where): Any previous xrays taken? Y N
Does anyone in the family (parents/siblings) have a history of dental decay? Y N
Has your child had any unfavourable experiences in a dental or medical office? Y N If yes, please describe:
How would you describe your child's temperament?

How often does your child: (a) brush his/her teeth: _____ times per day	(b) floss his/her teeth: _____ times per day
Does your child use a fluoride toothpaste? Y N (Not sure ☐)	
Does your child take any vitamin supplements? Y N	Fluoride supplements? Y N
Does your child use a bottle or sippy cup? Y N	
Does your child have milk, juice or formula before bed? Y N	In the middle of the night? Y N
Does your child have any habits which might affect his/her teeth or mouth?	
Y N Breathes through mouth	Y N Sucks thumbs or fingers
Y N Grinds teeth	Y N Other

Health History

The following information is needed so we can give your child the best possible care. All information is confidential. The pediatric dentists will review the questions and explain any you may not understand. Please advise us of any medical changes, allergies and/or new medications at every appointment.

I. Does your child have, or has your child ever had any of the following conditions:

Y	N	Prematurity	Y	N	Bleeding or blood disorder
Y	N	Cleft, lip, cleft palate	Y	N	Heart murmur
Y	N	Craniofacial anomaly	Y	N	Heart or cardiovascular conditions
Y	N	Developmental Delay	Y	N	Transplant
Y	N	Attention Deficit (Hyperactivity) Disorder	Y	N	Respiratory or lung disorder
Y	N	Autism Spectrum Disorder	Y	N	Thyroid or other endocrine disorders
Y	N	Behavioral problems	Y	N	Kidney or Liver conditions
Y	N	Communication or speech problems	Y	N	Cancer
Y	N	Learning disorder	Y	N	Immune deficiency
Y	N	Seizure disorder	Y	N	HIV
Y	N	Cerebral Palsy	Y	N	Malignant Hyperthermia
Y	N	Head/brain injury	Y	N	Medical implant (shunt, central line, feeding tube)
Y	N	Trauma or accident	Y	N	Gastro-esophageal reflux
Y	N	Asthma	Y	N	Skin conditions
Y	N	Sleep Apnea	Y	N	History of abuse or neglect
Y	N	Is this child adopted?	Y	N	Have you ever been told that your child needs to take antibiotics before dental treatment?

II. **Does your child have, or has your child had, medical condition(s) not listed above, or being investigated for any condition(s)?**
If yes, please list.

III. **Does your child have any allergies?** ☐ **medication** ☐ **latex** ☐ **food/dyes** ☐ **environmental** ☐ **other**
If yes, please list.

IV. **Is your child taking any prescription medications, over-the-counter medicines, or natural remedies?**
If yes, please list.

V. **Has your child ever been hospitalized or had a general anesthetic?**
If yes, please describe for what and when.

Dentist's Summary and Precautions

CONSENT FOR INFORMATION and TREATMENT

It is necessary that a signed permission be obtained from a parent or guardian before any and/or all necessary dental services can be started, because your child is a minor. Authorization is hereby granted. If during the course of treatment, in the opinion of the dentists of Sayahh Kids Dental Care, any treatment or procedure differs from that now contemplated, in respect of which there is no reasonable opportunity for additional explanation and authorization, you further request and authorize him/her to do whatever he/she considers advisable. Furthermore, the individual indicated on this form will be responsible for any account incurred on this child for dental treatment and understands that the account is due at each appointment, or whatever arrangement has been previously mutually agreed upon with the dentists of Sayahh Kids Dental Care.

PRINTED NAME OF PARENT/GUARDIAN: _____ RELATIONSHIP: _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

MEDICAL UPDATES:

DATE: _____ CHANGE: _____ Signature: _____

DATE: _____ CHANGE: _____ Signature: _____

DATE: _____ CHANGE: _____ Signature: _____