Eastern Health

Child/Women's Health Program

Patient Information (Confidential)
Dental Clinic

MS1160 0366 05 2015

Name:

HCN:

Date of Birth:

Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely, IN INK. If you have any questions or need assistance, please ask us - we will be happy to help!

Date of Birth: _____

Name (first): _____ (Last): _____ Nickname _____ ☐ Male ☐ Female

Address: _____ City: _____ Province: _____ Postal Code: _____

If student, name of school/college: _____

Telephone numbers: (Home) _____ (Work) _____ (Cell) _____

Parent/Guardian Names: _____

Name of Family Physician : _____ Date last visited: _____

Previous Dentist (if applicable): _____

Social Services drug card (if applicable): ID # _____ File # _____ District # _____

Insurance Information: Dental Insurance ☐ Yes ☐ No Insurance Company: _____

Consent for Treatment:

I, being the (circle one of the following) Mother, Father, Guardian of (name) _____ hereby give my consent to the dentists to perform/administer such treatments, services, medications, anesthesia and/or behaviour management techniques that may be necessary to correct any oral deficiency, abnormality, infection and/or disease.

1) If any conditions are discovered in the course of the treatment which, in the opinion of the physician(s) authorized by this consent, require procedures in addition to or different from those described, I also authorize the performance of these procedures.
2) I will be informed of the proposed procedure and/or treatment. The alternatives to, the risks of, and the possibilities of complications from the procedure and/or treatment, including those related to anesthesia, will be explained to me in sufficient detail to permit me to make a reasonable decision in the granting of this request.
3) I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.
4) I consent to the taking and publication of any photographs in the course of this treatment for the purpose of advancing dental education.

I certify that I read and fully understand the above consent, that all my questions were answered and the explanations described above were made to me to my satisfaction.

DD/MONTH/YYYY

Date: _____ Signature of Consenting Party: _____

Eastern Health acknowledges and respects the privacy of individuals. This personal information is being collected under the authority of Sections 32 and 33 of the Access To Information and Protection of Privacy Act, and will be used for treatment and billing purposes. Please direct any questions about this collection to: Access and Privacy Office, Eastern Health, Southcott Hall, 777-8025.

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Dental /Medical History Form

AS2920 0422 03 2013

Name:

HCN:

Date of Birth:

What is your chief concern? _____

Is the patient taking any medications at this time (including Aspirin)? ☐ Yes ☐ No

If yes, please list: _____

_____

Please list all Allergies and their symptoms: (include Medication, Food or Environmental)

_____

_____

_____

_____

_____

_____

_____

_____

Does the patient have now or has ever had:

	Yes	No		Yes	No
Anemia	☐	☐	Hearing Problems	☐	☐
Asthma, Hayfever, Shortness of Breath	☐	☐	Heart Disease or Murmur	☐	☐
Behavior Problems/Autism (explain below)	☐	☐	Hemophilia/Blood Disorder/HIV	☐	☐
_____			Hepatitis/Jaundice/Liver Disease	☐	☐
Birth Defects	☐	☐	High Blood Pressure	☐	☐
Cancer/Tumors	☐	☐	Kidney Disease	☐	☐
Cerebral Palsy	☐	☐	Rheumatic Fever	☐	☐
Cleft Lip or Palate	☐	☐	Seizures	☐	☐
Diabetes	☐	☐	Sinus Problems	☐	☐
Downs Syndrome	☐	☐	Speech Problems	☐	☐
Ear Infections	☐	☐	Spina Bifida/Hydrocephalus	☐	☐
Excessive or Prolonged Bleeding	☐	☐	Tuberculosis or Other Lung Disease	☐	☐
Fainting Spells	☐	☐	Vision Problems	☐	☐

Is the patient in good health?	☐	☐
Has the patient had any injuries to the face, mouth or teeth?	☐	☐
Does the patient have any oral habits like thumb sucking or sleeping with the bottle?	☐	☐
Has the patient ever had any serious illness or operation?	☐	☐

If yes, please explain: _____

_____

_____

_____

Name: _____ Signature: _____ Date: DD/MONTH/YYYY

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