Eastern Health

Child/Women's Health Program

Patient Information (Confidential)
Dental Clinic

MS1160 0366 05 2015

_____
Name

_____
HCN

_____
Date of Birth (DD/MONTH/YYYY)

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!

Patient Name (first): _____ Last Name: _____ DOB: _____ ☐ Male ☐ Female

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

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

Parent/Guardian Names: _____ Email: _____

Name of Family Physician: _____ MCP Number: _____

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) I will be informed of diagnosis or problem noted, nature and purpose of the proposed treatment along with the risks and benefits of such treatments, the treatment alternatives available along with associated risks and benefits, the likely consequences of not having the treatment and estimated cost of each treatment option.

2) If any conditions are discovered in the course of the treatment which, in the opinion of the physician(s)/ dentist(s) authorized by this consent, require procedures in addition to or different from those described, I also authorize performance of these procedures.

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 use of 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.

_____ _____

Date: *DD/MONTH/YYYY* Signature of Consenting Party:

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Dental /Medical History Form

AS2920 0422 03 2013

Name _____

HCN _____

Date of Birth (DD/MONTH/YYYY) _____

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)

Has the patient been hospitalized for any illness? If yes, please explain:

Has the patient ever had a surgery? If yes, please list all previous operations.

Has the patient or any family member had a reaction to an anesthetic or sedation (e.g. malignant hyperthermia)? If yes, please explain:

Does the patient have now or has ever had:

	Yes	No		Yes	No
Asthma/Hayfever/Shortness of breath	☐	☐	Heart Murmur	☐	☐
Behavioural concerns (e.g. ADHD, autism)			Hepatitis, Jaundice or Liver Disease	☐	☐
Birth Defects	☐	☐	Immunocompromised (e.g. chemotherapy,		
Bleeding Problem or Disorder (e.g. blood clots			radiation, HIV)	☐	☐
or excessive bleeding)	☐	☐	Kidney Problems	☐	☐
Blood Pressure Problems	☐	☐	Diabetes	☐	☐
Cancer/Tumors	☐	☐	Rheumatic Fever	☐	☐
Cerebral Palsy	☐	☐	Prosthetic or Artificial Joint	☐	☐
Down Syndrome	☐	☐	Seizures, Epilepsy or Stroke	☐	☐
Ear Infection	☐	☐	Sinus Problems	☐	☐
Fainting Spells	☐	☐	Speech Problems	☐	☐
Hearing Problems	☐	☐	Spina Bifida/Hydrocephalus	☐	☐
Is the patient in good health?	☐	☐	Taken Steroids, Prednisone or Cortisone-		
Heart Problems (e.g. heart valve repair,			Like Drugs	☐	☐
infective endocarditis, heart condition from			Tuberculosis or Other Lung Disease	☐	☐
birth)	☐	☐			

Do you have any condition or disease not listed above? If yes, please explain: ☐ ☐

Does the patient smoke or chew tobacco? ☐ ☐

Does the patient drink more than 3 alcoholic beverages a day? ☐ ☐

Is the patient breastfeeding or pregnant? ☐ ☐

Has the patient had any injuries to the face, mouth or teeth? ☐ ☐

Does the patient have any oral habits like thumb sucking, grinding or sleeping with a pacifier or bottle? ☐ ☐

Does the patient have jaw pain? ☐ ☐

Name:_____ Signature:_____ Date: _____

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