CHILDREN'S & WOMEN'S HEALTH CENTRE OF BRITISH COLUMBIA
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

Dental Admission Form

PERSONAL HISTORY
All of the information which you provide on this form will be held in the strictest confidence. Although some questions may seem unimportant at the time, they may be vital in an emergency situation. Please ANSWER EACH QUESTION. Please ask the receptionist if you need assistance completing this form.

Patient's Name: _____ Home Phone: _____ Cell #: _____ Sex: M F

Primary Parent / Guardian / Foster Parent: _____

Purpose of visit: _____

Other siblings seen in this clinic? _____

Whom may we thank for this referral? _____

DEPARTMENTAL POLICY
We require that services are paid for at each visit as they are performed. However, in certain circumstances, arrangements for payment may be made by consulting the accounting staff.

Who is responsible for this account? _____

PLEASE INDICATE ONE OF THE FOLLOWING:

Dental Insurance: ❒ Yes ❒ No Social Worker: ❒ Yes ❒ No Social Worker's Name: _____

BAND Status #: _____ Social Service Program (Healthy Kids / BC Dental): ❒ Yes ❒ No

DENTAL INSURANCE FIRST COVERAGE:

Employee: _____ Birth Date (Day/Month/Year): _____

Employer: _____ Name of Insurance Company: _____

Program or Policy #: _____ Group # _____ Dept. # _____

Coverage: _____ %

DENTAL INSURANCE SECOND COVERAGE:

Employee: _____ Birth Date (Day/Month/Year): _____

Employer: _____ Name of Insurance Company: _____

Program or Policy #: _____ Group # _____ Dept. # _____

Coverage: _____ %

I authorize the doctor to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual fee for services. I understand that I am financially responsible for payments in full on all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part, by my dental care payor.

Parent's Signature _____ **Date** _____ **Dentist's Signature** _____ **Date** _____
(Day/Month/Year) **(Day/Month/Year)**

REGISTRATION

BC Children's Dentistry
MEDICAL HISTORY

1. Is your child under the care of a physician at present? Yes No
If yes, since when and why? _____

_____

2. Physician's name _____ Phone: _____

Address: _____

3. Does your child have a health problem? Yes No
If yes, please explain? _____

_____

4. Has your child ever had a serious illness or been in hospital? Yes No
If yes, please explain? _____

_____

5. Is your child receiving medication? Yes No

What? _____

6. Is your child allergic to any medicine, drugs or food or had a *bad reaction* to any drug, medicine or food? Yes No
If yes, please list: _____

_____

7. Does your child have any limitations to physical activities? Yes No
If yes, please explain: _____

_____

8. Does your child have problems:
❒ Concentrating ❒ Learning ❒ None of These
❒ Cooperating ❒ Understanding

9. Are your child's immunizations up to date? Yes No

10. Has your child ever had treatment for any of the following? *Please check those that apply.*
❒ Blood-Circulatory ❒ Endocrine Glands ❒ Heart ❒ Muscles ❒ Stomach / Intestine ❒ Skin ❒ Teeth
❒ Bones ❒ Eyes ❒ Liver ❒ Nervous System ❒ Kidney / Bladder ❒ Ears, Tonsils / Adenoids

11. Does your child have acquired immune deficiency / HIV? Yes No

12. Has your child ever tested positive for hepatitis? Yes No

13. Has your child been vaccinated for chicken pox? Yes No

14. Have you ever been told that your child has any of the following conditions? *Please circle any that apply.*

ALLERGY	BLOOD TRANSFUSIONS	DEVELOPMENTAL DELAY	HEARING LOSS	LATEX ALLERGY	NUTRITIONAL DEFICIENCY
ANEMIA	BRAIN INJURY	DIABETES	HEART TROUBLE	LEUKEMIA	PNEUMONIA
ARTHRITIS	CANCER	EMOTIONAL DISORDERS	HEMOPHILIA	LIVER PROBLEMS	PSYCHIATRIC CARE
ASTHMA	CEREBRAL PALSY	EPILEPSY	HEPATITIS	LUNG PROBLEMS	SCARLET FEVER
AUTISM	CHICKEN POX	EYESIGHT PROBLEMS	HIGH BLOOD PRESSURE	MALIGNANT HYPERTHERMIA	SEIZURES
BIRTH DEFECTS	CHILD ABUSE	FAINTING	HYPERACTIVE	MENTALLY CHALLENGED	SPEECH PROBLEMS
BLEEDING	CLEFT LIP / PALATE	HEADACHES	KIDNEY PROBLEMS	MUSCULAR DYSTROPHY	TUBERCULOSIS

OTHER: _____

Parent's Signature _____ **Date** _____ **(Day/Month/Year)**

Dentist's Signature _____ **Date** _____ **(Day/Month/Year)**

OFFICE USE ONLY COMMENTS

Snoring	**Y**	**N**	
Frequency	**1/7**	**3/7**	**7/7**
Sleep Disturbance	**Y**	**N**	
Sleep Apnea	**Y**	**N**	
MD Consult	**Y**	**N**	
PAC Required	**Y**	**N**	
ADP	**Y**	**N**	
ELOS	_____ **Days**		

ADDITIONAL PARENT COMMENTS

MEDICAL HISTORY

DENTAL HISTORY

1. Has your child had previous dental treatment? Yes No

   If so, when? _____

2. Has your child ever had an unpleasant dental experience? Yes No

   If yes, please explain? _____

3. Have there been any injuries to the teeth or mouth? Yes No

   If yes, please explain? _____

4. Does your child have a toothache or other urgent dental problems? Yes No

5. Was your child referred *for / or* do you wish:
   ❒ Consultation ❒ Complete Treatment ❒ Specific Problem

6. Is either parent nervous or anxious about their own dental treatment? Yes No

7. Has your child ever received a local anesthesic (freezing)? Yes No

DENTAL DISEASE PREVENTION

1. When does your child brush his/her teeth? ❒ very seldom ❒ morning
   ❒ after eating any food ❒ right after meals ❒ before going to bed

2. Have you ever been taught how to floss or brush? Yes No

3. Does your child use dental floss? Yes No

4. Does someone
   ❒ assist your child with tooth cleaning? Yes No
   ❒ inspect the tooth cleaning? Yes No

5. Does your child use a fluoride containing toothpaste? Yes No

6. Does your child eat between meals? Yes No

7. Does your child eat sweets, drink soft drinks / juice
   ❒ more than once a day ❒ once per week
   ❒ less than once per week

8. How does your child receive fluoride?
   ❒ well water ❒ fluoride drops or tablets
   ❒ fluoride gel or rinses ❒ not at all

9. How was your child fed as an infant? ❒ breast ❒ bottle

I attest to the accuracy of information on these 3 pages.

OFFICE USE ONLY COMMENTS

Pain	**Y**	**N**
❒ Eating	❒ Sleeping	
❒ Max	❒ Mand	
❒ Left	❒ Right	
❒ Anterior	❒ Posterior	

FEVER **Y** **N**

EATING
❒ No problem ❒ Difficulty

SWELLING	**Y**	**N**
❒ Intraoral	❒ Extraoral	
❒ Max	❒ Mand	
❒ Left	❒ Right	

ANTIBIOTIC **Y** **N**

DJ: _____

R: _____

CODE: _____

TARGET TIME: _____

Parent's Signature _____ **Date** _____ **(Day/Month/Year)** **Dentist's Signature** _____ **Date** _____ **(Day/Month/Year)**

DENTAL HISTORY

CHILDREN'S & WOMEN'S HEALTH CENTRE OF BRITISH COLUMBIA
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Please review your previous medical history (dated / /) and advise your dentist if there are any changes.

1. Has there been any change in your child's health, such as serious illnesses, hospitalizations or new allergies? If yes, please specify.

❒ YES ❒ NO ❒ NOT SURE / MAYBE

2. Is your child taking any new medications or has there been any change in your child's medications? If yes, please specify.

❒ YES ❒ NO ❒ NOT SURE / MAYBE

3. Since your previous visit has a new heart problem been diagnosed or is there any change in an existing heart problem?

❒ YES ❒ NO ❒ NOT SURE / MAYBE

4. When was your child's last medical checkup?

5. Were any problems identified? If yes, please explain. ❒ YES ❒ NO ❒ NOT SURE / MAYBE

DENTIST'S NOTES

To the best of my knowledge, the above information is correct:

Parent's Signature _____ **Date** _____ **(Day/Month/Year)** **Dentist's Signature** _____ **Date** _____ **(Day/Month/Year)**

RECALL HISTORY