

Patient Registration

Child's Contact Information

Child's Name _____ Preferred Name _____
Last First Initial

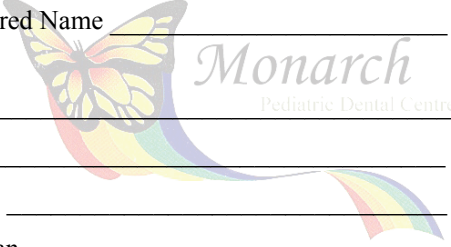
Male Female DOB _____

Child lives with: _____

Child's Home Address _____ Child's Home Phone _____

Child's Care Card No. _____

City _____ Province _____ Postal Code _____ Ministry Sponsored Plan _____



Guardian Information

<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other _____ Name _____ <small>Last First Initial</small> DOB _____ E-mail Address _____ Cell Phone _____ Work Phone _____ Insurance Information Name of Insurance Co. _____ Member ID / Cert. No. _____ Group Plan / Policy No. _____ Childs Dependent No. _____ Employer _____	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other _____ Name _____ <small>Last First Initial</small> DOB _____ E-mail Address _____ Cell Phone _____ Work Phone _____ Insurance Information Name of Insurance Co. _____ Member ID / Cert. No. _____ Group Plan / Policy No. _____ Childs Dependent No. _____ Employer _____
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Emergency Contact

Name _____ Phone Number _____

Whom may we thank for referring you?

Dentist Physician Health Dept. Friend Name _____
 Yellow Pages Other _____

Personal Information Protection Act Consent Box

I consent that any information given to Monarch Pediatric Dental Centre is to:

<input type="checkbox"/> YES <input type="checkbox"/> NO communicate with other health professionals, such as dentists, doctors etc. on you and your child's behalf.	<input type="checkbox"/> YES <input type="checkbox"/> NO communicate related services and activities provided by Monarch. Such as a Monarch newsletter or appointment reminder card
<input type="checkbox"/> YES <input type="checkbox"/> NO communicate with insurance providers on your behalf to facilitate your child's treatment.	SIGNATURE _____ DATE _____

I acknowledge that I am financially responsible for all charges. I am expected to pay for the services provided to my child on the day the services are rendered. I will be provided with an estimate of the fee for services recommended based on the initial treatment plan. If I am unable to commit to my scheduled appointment and fail to give a 24 hour cancellation notice ahead of time, I understand I will be charged for the appointment. I authorize release, to my insuring company plan administration, the information contained in claims submitted electronically or manually.

SIGNATURE _____ DATE _____

Child's Medical & Dental History



Child's Name: _____ Nickname: _____ Date: _____

Medical Information

Child's Physician: _____ Telephone: _____ Address: _____

Specialty Care Provider: _____ Telephone: _____

Does your child have a history of allergies/sensitivities/adverse reactions to any medications (Penicillin, Latex, etc)?

YES NO If yes, please explain _____

Does your child have environmental allergies? YES NO

If yes, please explain _____

Does your child have or has your child ever had any of the following?

	YES	NO		YES	NO
A. Heart disease, murmur or rheumatic fever? Type _____ If yes, has your child's doctor recommended antibiotics before dental work?	<input type="checkbox"/>	<input type="checkbox"/>	N. Thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>
B. High or low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	O. Lung Disease (TB, ASTHMA , persistent cough)?	<input type="checkbox"/>	<input type="checkbox"/>
C. Hay fever, sinus problems or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	P. Epilepsy, seizures, fainting?	<input type="checkbox"/>	<input type="checkbox"/>
D. Herpes or cold sores?	<input type="checkbox"/>	<input type="checkbox"/>	Q. Smoking or chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>
E. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	R. Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
F. Emotional Problems?	<input type="checkbox"/>	<input type="checkbox"/>	S. Genetic Disorders? If yes, explain _____	<input type="checkbox"/>	<input type="checkbox"/>
G. Kidney Disease?	<input type="checkbox"/>	<input type="checkbox"/>	T. Premature Birth?	<input type="checkbox"/>	<input type="checkbox"/>
H. Cancer, tumors, or other growths?	<input type="checkbox"/>	<input type="checkbox"/>	U. Hearing or Sight problems?	<input type="checkbox"/>	<input type="checkbox"/>
I. Radiation or chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	V. Significant injuries or hospitalizations?	<input type="checkbox"/>	<input type="checkbox"/>
J. Immunological deficiency disease (ie. AIDS, leukemia)	<input type="checkbox"/>	<input type="checkbox"/>	W. Any behavioral issues such as Autism, or ADHD we should be aware of? If yes, explain _____	<input type="checkbox"/>	<input type="checkbox"/>
K. Liver Disease (hepatitis, jaundice)?	<input type="checkbox"/>	<input type="checkbox"/>	X. Any other major illness, surgery, infections or conditions? If yes, explain _____	<input type="checkbox"/>	<input type="checkbox"/>
L. Abnormal bleeding or blood transfusion? If yes, When _____	<input type="checkbox"/>	<input type="checkbox"/>			
M. Blood Dyscrasias?	<input type="checkbox"/>	<input type="checkbox"/>			

Is there anything else you would like us to know about your child? Any personality or temperament issues? Any special needs?

Dental Information

Family Dentist: _____ Telephone Number: _____

- What is your chief concern you would like examined today? Please explain:

- When was your child's last dental checkup and cleaning? _____
- Has your child been seeing a dentist for regular checkups and care? YES NO
- Has your child experienced any traumatic injuries? YES NO
If yes, explain: _____
- Has your child had any negative experiences with dentists or doctors?
What, if any: _____

I authorize the staff and dentist(s) at MPDC to examine and/or treat my child.

Signature: _____ Relationship to Child: _____ Date: _____ Dentist Initials: _____



Monarch

Pediatric Dental Centre

KID FRIENDLY WORDS

Dear Parents,

We would like your child to have a positive visit while in our office. We will deal honestly with each procedure - explaining, showing and then doing. However we try to avoid words that scare children. So we would like to encourage you to use “kid friendly” words!

please use.....

sleepy juice

whistler or mister bumpy

wiggle a tooth

sugar bug

count teeth

tickle teeth

toothpick or tooth counter

raincoat

button

magic air

instead of.....

needle or shot

drill

yank or pull out

decay or cavity

examination

cleaning

explorer

rubber dam

clamp

gas or nitrous oxide

Thank you for helping us create a good experiences for your child!