Dr. Doug Sims, D.M.D.

Welcome to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile healthy and beautiful for a lifetime.

YOUR CHILD

Child's Name (in full)_____ Nickname_____
Date of Birth_____ Age_____ Home Telephone_____
Home Address_____
School_____ Grade_____ Favorite Activity/Hobby_____

PARENTS

Parent's Name_____ Parent's Daytime Telephone_____
Parents's Name_____ Parent's Daytime Telephone_____
Legal Guardian / Care Provider's Name_____ Telephone_____
Parent's Marital Status ☐ Married/Common Law ☐ Separated ☐ Divorced ☐ Widowed

RESPONSIBLE PARTY

Who is responsible for making appointments? Name_____
Relationship_____ Best Daytime Telephone_____

Who will be responsible for the payment of the account? Name_____
Relationship_____ Best Daytime Telephone_____
Address (if different from child)_____

PAYMENT OPTIONS

To help keep the cost of dentistry down and to continue to provide quality care to our valued patients, we only accept payment in full the day of treatment.

Please check the option(s) most convenient for you to settle your account in full, today.

☐ Cash / Cheque / Debit (in full) the day of treatment

☐ Visa Account #_____ expiry____/____

☐ MasterCard Account #_____ expiry____/____

Cardholder _____ x_____
print name signature

DENTAL INSURANCE

Policy Holder Name_____Employer_____
Policy Holder Date of Birth_____ Insurance Carrier_____
Plan/Group #_____Certificate/ID #_____
Deductible $_____ Maximum $_____ Basic (A) _____% Major (B) _____ Ortho (C) _____
Does plan cover fluoride? _____ sealants? _____ white fillings on baby teeth/molars? _____
Check-up every: (circle one) 6 9 months. Plan benefits to age (circle one) 19 21 25

MEDICAL HISTORY

To help us provide your child with the most effective treatment and reduce the chance of unnecessary complications, please take a moment to answer the following questions as accurately as you can.

Name of child's physician _____ Date of last physical examination_____

Is your child taking any drugs or medications? ☐ No ☐ Yes

Drug _____ Reason _____

Drug _____ Reason _____

Drug _____ Reason _____

Is your child allergic to any drugs or medications? ☐ No ☐ Yes List _____
Has your child ever had an unfavourable reaction or allergy to local anaesthetic (freezing)? Please describe _____
Child's medical CareCard # _____ Latex allergy ☐ No ☐ Yes
Are any other conditions or problems not previously listed? Please describe _____
_____
We offer dental treatment under nitrous oxide. Does this interest you? ☐ No ☐ Yes

DENTAL HISTORY

We take the responsibility of caring for your child's oral health very seriously. The following is a series of questions that will help us tailor dental treatment to suit your child's dental needs. As well, this information will assist us in providing quality treatment in the most comfortable manner possible.

When was your child's last dental visit? _____ Name of dentist seen? _____
How frequently did your child see their last dentist? _____
Is your child having any emergency dental problems? _____
Do any of the following cause tooth discomfort? ☐ Hot ☐ Cold ☐ Sweet ☐ Chewing
Do you brush your child's teeth? _____Does your child brush their own teeth? _____
Is dental floss used regularly? _____ Is your child receiving fluoride supplements? _____
Does your child usually have cavities at check-ups? _____ Has your child had braces? _____
Has your child ever had an unpleasant dental experience? Please describe _____
_____
We only take radiographs (x-rays) when necessary. Does this pose any concerns for you? _____

INFORMED CONSENT/GENERAL RELEASE

I, the undersigned, state that I have provided an accurate and complete medical/dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this medical/dental history and consent to my child's medical physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of dental anaesthetic as necessary. I also understand that I assume the responsibility for any and all fees associated with these procedures and services.

_____ X_____
print name of parent/guardian signature