Patient Information

Children Below 18 Years of Age

AXIS Dental Group | Brampton
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WWW.**AXIS**DENTAL.CA

DATE: ______________________________

Your cooperation in filling out the data on the confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with this office.

Child's Full Name (last/first/middle) ______________________________
Nickname ______________________ Usually Called ______________________
School ______________________________
Age ________ Date of Birth (dd/mm/yyyy) ______________ Sex ______________
Favorite Toy ______________ Favorite Person ______________ Favorite Sport______________
Parent's Name (last/first/middle)______________________________
Address______________________________
Postal Code ______________________Home Phone ______________________

Person Responsible for Account

Name (last/first/middle) ______________________________
Address______________________________
Postal Code ______________Phone ______________ Date of Birth ______________
Employed By______________________ Occupation ______________________
Dental Insurance ☐ YES ☐ NO Name of Company______________________
Family Benefits ☐ YES ☐ NO Policy No. ______________ %Covered ______________
S.I.N./Cert # ______________________________
Authorization Needed ☐ YES ☐ NO (if yes, fill in mailing address of insurance company below)
Address______________________________
Postal Code______________
Family Physician ______________ Phone ______________Previous Dentist ______________
Whom may we thank for referring you ______________________________
In Case of Emergency Notify (Name):______________________________
Address______________________________
Relationship ______________________Phone ______________________
Are You Seeking Treatment For Any Particular Reason and/or Routine Dental Care? ______________
Other Comments ______________________________
Brothers' & Sisters' Names and Ages ______________________________
____

Confidential Medical History

01. When did your child last visit the physician? ______________ Reason ______________
02. Has your child ever had any serious illness or been in the hospital? ☐ YES ☐ NO
If yes, describe______________________________
03. Does your child have any known medical, physical or mental handicaps? ☐ YES ☐ NO
If yes, describe______________________________
04. Has your child ever had any of the following ?

☐ Measles ☐ Kidney Disease ☐ Lung Disease ☐ Adenoids ☐ Ear Trouble ☐ Asthma ☐ Operations
☐ Liver Disease ☐ Ankle Swelling ☐ Gland Trouble ☐ Broken Bones ☐ Chest Pains ☐ Heart Trouble ☐ Mumps
☐ Scarlet Fever ☐ Tonsils ☐ Diabetes ☐ Abnormal Blood Pressure ☐ Nervous Disorder ☐ Physical Deformity ☐ Shortness of Breath
☐ Tuberculosis ☐ Jaundice ☐ Epilepsy ☐ Fainting Spell ☐ Rheumatic Fever ☐ Strep. Throat ☐ Hay Fever
☐ Chicken Pox ☐ Other

05. Has your child ever had or been tested positive for any immunocompromising disease? ☐ YES ☐ NO
If yes to any of the above, describe ______________________________

06. Has your child have/had rheumatic fever? ☐ YES ☐ NO
07. Has your child have/had heart disease or murmur? ☐ YES ☐ NO
08. Is your child allergic to anything? ☐ YES ☐ NO
If yes, describe______________________________

09. Does he or she bruise easily or bleed profusely for a long period of time? ☐ YES ☐ NO
10. Does your child have/had any blood disease? ☐ YES ☐ NO
11. Does your child have/had any emotional problems? ☐ YES ☐ NO
12. Is your child now taking, or has taken or had taken:

☐ Penicillin ☐ Other Antibiotics ☐ Cortisone ☐ Local Anaesthesia ☐ General Anaesthesia ☐ Other drugs

13. Has he or she had any unfavourable reaction to these drugs? ☐ YES ☐ NO

14. Is there a history of any inherited diseases in the family? ☐ YES ☐ NO
If yes, describe______________________________

Dental History

Has your child had previous dental care? ☐ YES ☐ NO If Yes, When? ____________
Has he or she ever had an unpleasant experience associated with dental treatments? ☐ YES ☐ NO
If yes, describe______________________________
Is there a family history of : (Tick, if YES)

☐ High decay rate ☐ Spaced teeth ☐ Extra teeth ☐ Cleft lip/or palate
☐ Tooth deformity ☐ Missing teeth ☐ Crooked teeth ☐ Gum disease

If yes, describe :______________________________
Does your child have any oral habits such as : (Tick, if YES)

☐ Thumbsucking ☐ Lip Biting ☐ Mouth Breathing ☐ Chewing (e.g. Pencils)
☐ Fingersucking ☐ Nail Biting ☐ Teeth Grinding ☐ Tounge Thrusting

OFFICE POLICY: When an appointment is made, that time is specifically reserved for you only and will not be given to anyone else unless you call and cancel. It costs us approximately $400 per hour to keep our office open. When enough notice is not given (minimum 48 hours) to cancel, a $50 charge will apply (insurance plans do not cover this amount). Office policy is that; services are paid for at each visit as they are performed. However in certain circumstances arrangements for payment may be made by consulting doctor. Please indicate one of the following with check mark:

☐ I have dental insurance. ☐ I wish to pay each visit as the services are performed. ☐ I will like to know the total fee for all the work to be done, as well as the number of appointments necessary, so that I can pay equal portions at each appointment. ☐ I wish to discuss special arrangements for payment with the doctor.

CONSENT FOR TREATMENT: This is to certify that I, the undersigned, consent to the performing of the denial procedures agreed to be necessary or advisable including the use of general anaesthetic as indicated and I will asaume responsibility for fees associated with those procedures. I authorize this office to contact my previous dentist, medical doctor(s), Insurance oompany, plan administrative at work and share Information as needed. As well as, to submit insurance claims electronically.

Parent/Guardian Signature______________________ Dentist's Signature ______________________

Date ______________________ Date ______________________