LUNAR SMILE DENTISTRY

475 Wharncliffe Rd S, London, ON N6J 2N1
226-884-2573 · info@lunarsmiledentistry.ca
lunarsmiledentistry.ca

NEW PATIENT FORM

Medical/Dental History (Child)

How to return this form. Open this form in Adobe Acrobat Reader (free) to type your answers, then save it and email it to info@lunarsmiledentistry.ca. You can also print it and bring it to your first visit. Questions? Call us at 226-884-2573.

Please note. The parent or guardian who comes to the appointment with the child is responsible for payment at the time of the visit.

About your child

Child's full name | Preferred name / nickname | Date of birth

Gender: ○ Boy ○ Girl ○ Another gender ○ Prefer not to say

Home address | City | Postal code

School | Brothers or sisters we see

Who can we thank for referring you to us?

Parent / guardian 1

Full name | Relationship to child | Date of birth

Mobile phone | Home phone | Work phone | Employer

Email

Parent / guardian 2

Full name | Relationship to child | Date of birth

Mobile phone | Home phone | Work phone | Employer

Email

Today's visit

Adult coming with the child | Relationship to child

Do you have legal custody of this child? ○ Yes ○ No

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Child's doctor and general health

Doctor's name

Doctor's phone

Is your child currently under a doctor's care for a specific health concern? ◯ Yes ◯ No

If yes, please explain

How would you describe your child's general health?

◯ Good ◯ Fair ◯ Poor

Dental insurance

Is your child covered by the Canadian Dental Care Plan (CDCP)?

◯ Yes ◯ No

Primary insurance

Insurance company

Group / policy number

Member / ID number

Policy holder name

Relationship to child

Policy holder date of birth

Policy holder employer

Secondary insurance (if any)

Insurance company

Group / policy number

Member / ID number

Policy holder name

Relationship to child

Policy holder date of birth

Policy holder employer

Dental history

Is this your child's first visit to a dentist? ◯ Yes ◯ No

If not, when was the last visit?

Were x-rays taken at a previous dental visit? ◯ Yes ◯ No

Has your child ever injured their teeth, face or mouth? ◯ Yes ◯ No

If yes, please explain

What is the main reason for this visit?

Has your child had a difficult experience with past dental care? ◯ Yes ◯ No

If yes, please explain

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Does your child…

Have tooth pain right now?	○ Yes	○ No	Have jaw pain or clicking?	○ Yes	○ No
Brush every day?	○ Yes	○ No	Floss every day?	○ Yes	○ No
Suck their thumb or fingers?	○ Yes	○ No	Use a soother or bottle?	○ Yes	○ No
Suck or bite their lip?	○ Yes	○ No	Bite their nails?	○ Yes	○ No

How would you describe your child's temperament?

☐ Outgoing ☐ Shy ☐ Nervous ☐ Fearful ☐ Strong-willed

Medical history

Does your child have now, or have they ever had, any of the following?

Abnormal bleeding	○ Yes	○ No	Allergy to any medication	○ Yes	○ No
Allergy to latex	○ Yes	○ No	Hay fever / seasonal allergies	○ Yes	○ No
Asthma	○ Yes	○ No	Autism spectrum disorder	○ Yes	○ No
Sensory processing difference	○ Yes	○ No	Speech delay	○ Yes	○ No
Developmental delay	○ Yes	○ No	Emotional or behavioural concerns	○ Yes	○ No
Attention difficulties (e.g. ADHD)	○ Yes	○ No	Hearing loss	○ Yes	○ No
Physical disability	○ Yes	○ No	Cerebral palsy	○ Yes	○ No
Down syndrome	○ Yes	○ No	Condition present from birth	○ Yes	○ No
Seizures / epilepsy	○ Yes	○ No	Diabetes	○ Yes	○ No
Heart condition or murmur	○ Yes	○ No	Hemophilia / blood disorder	○ Yes	○ No
Sickle cell disease or trait	○ Yes	○ No	Hepatitis	○ Yes	○ No
Kidney or liver condition	○ Yes	○ No	Rheumatic or scarlet fever	○ Yes	○ No
Tuberculosis	○ Yes	○ No	Cancer	○ Yes	○ No
Hospital stay	○ Yes	○ No	Surgery	○ Yes	○ No
Pregnancy (if applicable)	○ Yes	○ No			

Please describe any serious medical condition your child has or has had

All medications your child takes

Medications your child is allergic to

Any other allergies

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Agreement and signature

Please tick each statement to confirm it is true for you.

- ☐ The information I have given is correct to the best of my knowledge.
- ☐ I will tell the office about any change in my child's health or medications.
- ☐ I authorize the dental team to examine my child and to provide the dental care that has been discussed with me.
- ☐ I understand that this information is kept confidential, as described in our privacy policy.

Our office follows the infection prevention and control standards of the Royal College of Dental Surgeons of Ontario.

Signed by: ○ Parent ○ Legal guardian ○ Substitute decision-maker

Full name of person signing	Relationship (if not the patient)	Email

Signature

X _____

Date (YYYY-MM-DD)

Sign with the Fill & Sign tool in Adobe Acrobat Reader, or print this page and sign by hand.