DR. ERROL R. NEZON
Paediatric Dentist

Welcome to our office. Please complete this form as accurately as possible so that we can provide the best dental care for your child.

GENERAL INFORMATION

CHILD'S FULL NAME ______________________ (USUALLY CALLED) ______________

HOME ADDRESS: STREET ______________________

CITY ______________________ POSTAL CODE ______________

HOME PHONE NUMBER ______________________

MOTHER'S NAME ____________ EMPLOYED BY ____________ PHONE NUMBER (____) ____________

FATHER'S NAME ____________ EMPLOYED BY ____________ PHONE NUMBER (____) ____________

CHILD'S PHYSICIAN / PAEDIATRICIAN ______________________

NAME OF LAST DENTIST SEEN BY YOUR CHILD ______________________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: NAME ______________________

ADDRESS ______________________

DENTAL INSURANCE COMPANY NAME ______________ PLAN MEMBER'S NAME ______________

DATE OF BIRTH ____________ POLICY/GROUP # ____________ CERTIFICATE/ID NUMBER ____________

CHILD'S HISTORY

AGE ________ DATE OF BIRTH ____________ PLACE OF BIRTH ____________

SCHOOL ______________________ GRADE OR LEVEL ______________

FAVOURITE SPORT, HOBBY, TOY, ACTIVITY OR PET ______________________

NAMES AND AGES OF SIBLINGS ______________________

REASON FOR SEEKING DENTAL CARE: i.e. ROUTINE EXAMINATION, TOOTHACHE, ACCIDENT, CROOKED TEETH etc.

____

MEDICAL HISTORY

WHEN DID YOUR CHILD LAST VISIT THE PHYSICIAN AND THE REASON FOR THAT VISIT? ______________________

____

DID THE MOTHER HAVE ANY PROBLEMS DURING PREGNANCY OR DELIVERY? YES ☐ NO ☐

PLEASE EXPLAIN ______________________

HAS YOUR CHILD EVER HAD A SERIOUS ILLNESS OR BEEN HOSPITALIZED? YES ☐ NO ☐

PLEASE EXPLAIN ______________________

DOES YOUR CHILD HAVE ANY ALLERGIES? YES ☐ NO ☐

PLEASE LIST ______________________

DOES YOUR CHILD BRUISE EASILY OR BLEED EXCESSIVELY WHEN CUT? YES ☐ NO ☐

HAS YOUR CHILD EVER HAD A BLOOD TRANSFUSION OR INTRAVENOUS FLUIDS? YES ☐ NO ☐

IS YOUR CHILD RECEIVING ANY MEDICATION OR DRUGS? YES ☐ NO ☐

PLEASE LIST ______________________

HAS YOUR CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

- ☐ ANEMIA
- ☐ ASTHMA
- ☐ ATTENTION DISORDER (A.D.D.)
- ☐ CEREBRAL PALSY
- ☐ CHICKEN POX
- ☐ DIABETES
- ☐ EAR INFECTIONS
- ☐ EMOTIONAL PROBLEMS
- ☐ EPILEPSY
- ☐ FAINTING
- ☐ FRACTURES
- ☐ HEADACHES
- ☐ HEARING
- ☐ HEART MURMUR
- ☐ HEART PROBLEM
- ☐ HEPATITIS
- ☐ JAUNDICE
- ☐ KIDNEY OR BLADDER
- ☐ LIVER
- ☐ LUNG DISEASE
- ☐ MALIGNANCIES
- ☐ MEASLES
- ☐ MONONUCLEOSIS
- ☐ MUMPS
- ☐ RHEUMATIC FEVER
- ☐ SEIZURE DISORDER
- ☐ SKIN DISEASE
- ☐ SPEECH OR LEARNING DISORDER
- ☐ SURGERY
- ☐ THYROID

PLEASE PROVIDE ADDITIONAL INFORMATION ABOUT ANY ITEMS THAT WERE INDICATED ABOVE:

____

(OVER PLEASE)

____

DENTAL HISTORY

IS THIS YOUR CHILD'S FIRST VISIT TO THE DENTIST? YES ❑ NO ❑

DATE OF YOUR CHILD'S LAST VISIT TO A DENTIST? ____

WHAT SERVICES WHERE PERFORMED THERE? ____

AGE AT WHICH THE BOTTLE WAS COMPLETELY STOPPED? ____

HAS YOUR CHILD COMPLAINED ABOUT ANY DENTAL PROBLEMS? YES ❑ NO ❑

PLEASE EXPLAIN ____

HAS YOUR CHILD HAD ANY UNHAPPY DENTAL EXPERIENCES? YES ❑ NO ❑

PLEASE EXPLAIN ____

HAS YOUR CHILD HAD ANY INJURIES TO THE MOUTH, TEETH OR HEAD? YES ❑ NO ❑

PLEASE EXPLAIN ____

DOES YOUR CHILD HAVE ANY ORAL HABITS:

❑ THUMB OR FINGER SUCKING
❑ PACIFIER
❑ MOUTH BREATHING
❑ NAIL BITING
❑ TEETH GRINDING
❑ NIGHT TIME BOTTLE
❑ OTHER

HAS YOUR CHILD HAD ANY ORTHODONTIC TREATMENT? YES ❑ NO ❑

PLEASE EXPLAIN ____

IS THERE ANY FAMILY HISTORY OF CROOKED TEETH, MISSING OR EXTRA TEETH, HIGH CAVITY RATE, ETC? YES ❑ NO ❑

PLEASE EXPLAIN ____

DOES YOUR CHILD BRUSH HIS/HER TEETH DAILY? YES ❑ NO ❑

DOES SOMEONE ASSIST YOUR CHILD WITH TOOTHBRUSHING? YES ❑ NO ❑

BY WHAT MEANS DOES YOUR CHILD RECEIVE FLUORIDE:

❑ DRINKING WATER
❑ TOOTHPASTE
❑ VITAMINS
❑ TABLETS
❑ SCHOOL PROGRAMS
❑ NONE

IS THERE ANY ADDITIONAL INFORMATION WHICH YOU FEEL MAY BE HELPFUL IN OUR CARE OF YOUR CHILD?

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____

____

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION

- TO ASSESS YOUR HEALTH NEEDS AND PROVIDE SAFE AND EFFICIENT DENTAL CARE.
- TO ENABLE US TO CONTACT AND MAINTAIN COMMUNICATION WITH YOU TO DISTRIBUTE HEALTH-CARE INFORMATION AND TO BOOK AND CONFIRM APPOINTMENTS.
- TO COMMUNICATE WITH OTHER TREATING HEALTH-CARE PROVIDERS, INCLUDING OTHER DENTISTS, PHYSICIANS, PHARMACISTS AND LAB TECHNICIANS.
- FOR TEACHING AND DEMONSTRATING PURPOSES ON AN ANONYMOUS BASIS.
- TO COMPLETE AND SUBMIT DENTAL CLAIMS FOR THIRD PARTY ADJUDICATION AND PAYMENT.
- TO COMPLY WITH LEGAL AND REGULATORY REQUIREMENTS.
- TO DELIVER YOUR CHARTS AND RECORDS TO THE DENTIST'S INSURANCE CARRIER TO ENABLE THE INSURANCE COMPANY TO ASSESS LIABILITY AND QUANTIFY DAMAGES, AS NECESSARY.
- TO INVOICE FOR GOODS AND SERVICES.
- TO PROCESS CREDIT CARD PAYMENTS.
- TO COLLECT UNPAID ACCOUNTS.

SIGNATURE ____ RELATIONSHIP ____ DATE ____