Children's Medical & Dental History

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In order to render optimum health service, it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment, they may be vital in case of emergency. Therefore PLEASE ANSWER EVERY QUESTION.
Please feel free to ask receptionist for help in completing this form.

Personal Information

Child's First Name:					
Child's Last Name:			Date of birth:		
Parent/Guardian:					
Address:					
City:			Postal Code:		
Home Number:	Cell Number:		Work Number:		
Email address:					
Is it ok that we contact parent/guardian at the above contact number(s)?	Yes	No	Do you have dental insurance?	Yes	No

Medical History

Is the child presently under the care of a physician?	Yes	No
If so, please explain		
Has the child ever had any serious illness or been treated in the hospital?	Yes	No
If so, please explain		
Is the child taking and medication?	Yes	No
If so, what is it?		
Is the child allergic to any food or medication?	Yes	No
If so, please list		
Has the child ever had any unfavourable reaction to any previous medical or dental care?	Yes	No

Has child ever had any of the following conditions?

Measles	Yes	No	Shortness of breath	Yes	No	Aids or exposure to HIV virus	Yes	No
Mumps	Yes	No	Lung disease	Yes	No	Blood disease	Yes	No
Chicken Pox	Yes	No	Fainting spells	Yes	No	Diabetes	Yes	No
Scarlet Fever	Yes	No	Ankles swelling	Yes	No	Epilepsy	Yes	No
Strep Throat	Yes	No	Pains in chest	Yes	No	Prosthetic heart valves/joints	Yes	No
Tonsilitis	Yes	No	Heart trouble	Yes	No	Kidney disease	Yes	No
Earaches	Yes	No	Rheumatic Fever	Yes	No	Liver disease	Yes	No
Hayfever	Yes	No	Bruise easily	Yes	No	Tuberculosis	Yes	No
Asthma	Yes	No	Prolonged bleeding	Yes	No	Nervous disorder	Yes	No
Muscular Dystrophy	Yes	No	Multiple Sclerosis	Yes	No	Psychiatric care	Yes	No
Malignant Hyperthermia	Yes	No	Hepatitis B/C	Yes	No	Other major diseases	Yes	No

Dental History

Has the child had previous dental care?	Yes	No
If so, how long ago?		
Has the child ever had an accident, injury or surgery about the mouth?	Yes	No
If so, please explain		
Is the child nervous about visiting the dentist?	Yes	No
Have the child's teeth ever been treated with decay preventing fluoride?	Yes	No
Has the child ever had orthodontic treatment?	Yes	No
Is there a family history of: high decay rate, gum disease, malformed teeth, extra teeth, missing teeth or crooked teeth?		

Reviewed by Doctor:_____ Date:_____

DR. ALY ADATIA
PREVENTIVE DENTAL CARE
PATIENT CONSENT FORM: FOR COLLECTION USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients. In this office, Dr. Aly Adatia, acts as the Privacy Information Officer. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information. Attached to this consent form, we have outlined what our office is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

Do not hesitate to discuss our policies with me or any members of our office staff. Please be assured that every staff person in our office is committed to ensuring that you receive the best quality dental care. Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined her how our office is using and disclosing your information. This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and to ensure continuous high quality service
- To assess your health needs
- To provide health care
- To advise you of treatment plans
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide treatment, care and services in relationship to the oral and maxillofacial complex and dental care generally
- To communicate with other treating health-care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists
- To allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- To allow us to efficiently follow-up for treatment, care and billing
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit dental claims for third party adjudication and payment.

Patient Name: ….....

Patient Signature: ..... Date: .....