SUNRISE DENTAL

Child New Patient Form

Dependent Information:

Name: _____ Male ☐ Female ☐
(Last Name) (Legal First Name) (Preferred Name)

Date of Birth: _____/_____/_____ Alberta Health Care # _____
(day) (month) (year)

Home Address: _____

City _____ Province _____ Postal Code _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Email: _____

Our system will text or email appointment reminders to you. Please let us know which method you prefer

Parent/Guardian Information:

Name: _____
(Last Name) (First Name)

Date of Birth: _____/_____/_____
(Day) (Month) (Year)

Do you have Insurance? Yes ☐ No ☐ (If yes, please give your insurance card to the receptionist with this form)

Who may we thank for referring you? _____

In case of emergency, we should notify: _____
(Name) (Relationship) (Phone #)

Family Doctor: _____
(Name) (Phone#)

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in all of the following.

1. Has your child been to the dentist before? ..... Yes ☐ No ☐
   If yes, when? _____
2. Was this a positive experience? ..... Yes ☐ No ☐
   If not, why? _____
3. When was his/her last medical check-up? _____
4. Is the child being treated for any medical condition at this time or have they been in the last year?
   If yes, why? _____ Yes ☐ No ☐
5. Is the child on any medications or herbal supplements or vitamins? ..... Yes ☐ No ☐
   If yes, please list. _____
6. Does he/she have any allergies? ..... Yes ☐ No ☐
   If yes, please list. _____

7. Has your child ever had a peculiar or adverse reaction to any medication or injection? ..... Yes☐ No ☐
   If yes, please explain. _____
   _____

8. Does your child have asthma? ..... Yes☐ No☐

9. Has your child ever been advised to take antibiotics before dental treatment? ..... Yes☐ No☐

10. Does your child have any conditions or therapies that could affect his/her immune system (e.g.: Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? ..... Yes☐ No☐
    If yes, please list. _____

11. Has the child ever had hepatitis, jaundice, or liver disease? .....Yes☐ No☐

12. Does he/she have a bleeding disorder or bleeding problems? ..... Yes☐ No☐

13. Has the child ever been hospitalized for any illness or operations? ..... Yes☐ No☐

    If yes, explain. _____

14. Does the child have, or have they ever had any of the following? (Please check)

☐ ADHD	☐ Angina/Chest Pain	☐ Arthritis
☐ Behavioral Disorder	☐ Cancer	☐ Developmental Disorder
☐ Diabetes	☐ Digestive Issues	☐ Drug/Alcohol Dependency
☐ Heart Attack	☐ Heart Disorder	☐ Heart Murmur
☐ Kidney Disease	☐ Lung Disease	☐ Pacemaker
☐ Seizures/Epilepsy	☐ Shortness of Breath	☐ Skin Condition
☐ Steroid Therapy	☐ Stomach Ulcers	☐ Stroke
☐ Snoring/Sleep Apnea	☐ Thyroid Disease	☐ Tuberculosis

15. Are there any conditions or diseases not listed above that the child has or has ever had? ..... Yes☐ No☐
    If so, what? _____

16. Are there any disease or medical problems that run in the child's family? ..... Yes☐ No☐

_____
_____

To the best of your knowledge, all the above information is correct:

_____ _____

Parent/Guardian Signature Date