

KIDS DENTAL INFORMATION



PATIENT'S NAME _____
Last First Initial

D.O.B.: _____ Gender (M/F): _____ Manitoba Health #: _____
DD / MM / YY

Address: _____
Street City

Province Postal Code

Contact Phone numbers:

Mother's name: _____ Home number: _____

Employed by: _____ Work # _____ ext: _____ Cell # _____

Father's name: _____ Home number: _____

Employed by: _____ Work # _____ ext: _____ Cell # _____

Please indicate which phone number is your preferred contact: _____

E-mail: _____

Who may we thank for this referral? _____

A promotional graphic with a green, textured background. On the left, three cartoon children (two boys and one girl) are smiling. In the center, the "Kids dental" logo is displayed. To the right, the text reads: "TUXEDO PARK SHOPPING CENTRE", "128-2025 CORYDON AVENUE", and "222-kids (5437)".

**choose to be,
Cavity Free!**

222-kids (5437)

REGISTRATION

KIDS DENTAL



Method Payment:

Cheque

Credit Card

Cash

Kids Dental Billing Policy

Kids Dental is a specialty office with all fees collected after every appointment.

We accept cash – interac, cheques and all major credit cards.

We do not accept assignment from dental insurance. However we are pleased to process your dental claims to your insurance carrier of choice for direct reimbursement.

Other Family Members in this Practice _____

DENTAL INSURANCE 1st COVERAGE

Employee Name: _____

D.O.B.: _____
DD / MM / YY

Employer: _____

Insurance Co.: _____

Group or Policy #: _____

Certificate #: _____

Employee #: _____

Division #: _____

I.D. #: _____

DENTAL INSURANCE 2nd COVERAGE

Employee Name: _____

D.O.B.: _____
DD / MM / YY

Employer: _____

Insurance Co.: _____

Group or Policy #: _____

Certificate #: _____

Employee #: _____

Division #: _____

I.D. #: _____

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist or medical professional.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature: _____ Date: _____

BILLING INFORMATION



PATIENT'S NAME: _____ DATE OF BIRTH: ____/____/____
DD MM YY

DENTAL HISTORY

Is this your child's first visit to the dentist? YES NO

If no: Previous Dentist: _____

Date of last visit: _____

Were any x-rays taken? YES NO

Have there been any injuries to your child's teeth (e.g. falls, chips, etc)? YES NO

If yes, describe: _____

MEDICAL HISTORY

Name of paediatrician or family physician: _____

Is your child currently taking any medications or drugs? YES NO

If yes, state why and list: _____

Has your child ever had a bad reaction to drugs, including antibiotics or local /general anaesthetics? YES NO

If yes, explain: _____

Has your child ever had surgery or been hospitalized? YES NO

If yes, explain: _____

Has your child ever been diagnosed with any of the following conditions (please circle):

- | | | | |
|---------------|----------------------|---------------------|---------------------|
| ADD/ADHD | Autism | Eye Problems | Rheumatic Fever |
| Allergies | Bleeding Disorder | Hearing Loss | Seizures |
| Drug | Cancer | Heart Disease | Sickle Cell Anaemia |
| Environmental | Cerebral Palsy | Hepatitis | Speech Problems |
| Food | Cleft Lip/Palate | HIV/AIDS | Syndrome: _____ |
| Latex | Developmental Delays | Kidney Disease | |
| Anaemia | Diabetes | Liver Disease | Other: _____ |
| Asthma | Epilepsy | Mentally Challenged | _____ |

Details: _____

Is there anything else we should know about your child's health or medical condition? YES NO

If yes, explain: _____

I acknowledge that the above information is complete and accurate.

Parent / Guardian Signature: _____ Date: _____

DENTAL DIET SURVEY

DIET ANALYSIS

In order to get a better idea of how foods might affect a child's cavities, we need to know what your child eats every day, particularly the sweet stuff. For each of the following foods we'd like you to guess about how often your child eats that food. Remember to think about what the child eats at school as well as at home. In the past week how often has your child eaten:

1. **Bread: [white or dark, including rolls, bagels, etc.]**
 1. Never
 2. A few times a week
 3. Almost every day
 4. Every day
 5. Several times a day
2. **Cookies:**
 1. Never
 2. A few times a week
 3. Almost every day
 4. Every day
 5. Several times a day
3. **Candy bars (chocolate):**
 1. Never
 2. A few times a week
 3. Almost every day
 4. Every day
 5. Several times a day
4. **Hard candies (sucking candies):**
 1. Never
 2. A few times a week
 3. Almost every day
 4. Every day
 5. Several times a day
5. **Chewing or bubble gum (with sugar):**
 1. Never
 2. A few times a week
 3. Almost every day
 4. Every day
 5. Several times a day
6. **Milk: [white milk, not chocolate milk or other milk products]**
 1. Never
 2. A few times a week
 3. Almost every day
 4. Every day
 5. Several times a day
7. **Drinks with sugar: [prompt: soda, hot chocolate or choc. milk, Hi C, Kool Aid, boxed drinks]**
 1. Never
 2. A few times a week
 3. Almost every day
 4. Every day
 5. Several times a day
8. **Red meat: [incl: hamburger, pork incl. ham & ribs, hot dogs, beef stew]**
 1. Never
 2. A few times a week
 3. Almost every day
 4. Every day
 5. Several times a day
9. **Other baked goods: [incl: pies, cakes, pastries, Twinkies & other Hostess cakes, Little Debbie, etc.]**
 1. Never
 2. A few times a week
 3. Almost every day
 4. Every day
 5. Several times a day
10. **Ice cream: [include: popsicles, frozen fruit bars, frozen yogurt]**
 1. Never
 2. A few times a week
 3. Almost every day
 4. Every day
 5. Several times a day
11. **Cereal with sugar: [include cereal with sugar already on it, and cereal with sugar added]**
 1. Never
 2. A few times a week
 3. Almost every day
 4. Every day
 5. Several times a day
12. **Green vegetables: [green beans, peas, etc.]**
 1. Never
 2. A few times a week
 3. Almost every day
 4. Every day
 5. Several times a day

A Diet score _____

Sugar Intake = sum(02, 03, 04, 05, 07, 09, 10, 11). (Range: 8 – 40).

A score greater than 16 = **moderate risk** A score greater than 24 = **high risk**

DENTAL KNOWLEDGE SURVEY

Now I'd like to ask you some of your opinions about dentistry and dental care. For each of the statements I'm going to read to ask you, I'd like you to tell me whether you think that statement is true or false. Even if you are not completely sure about a statement, try to answer True or False anyway. OK?

1. The amount of sugar my child eats affects his/her teeth.
 1. TRUE
 - or
 2. FALSE
2. If a person does eat sweets, it's better for the teeth to eat them with meals than between meals.
 1. TRUE
 - or
 2. FALSE
3. Only adults really need to brush their teeth.
 1. TRUE
 - or
 2. FALSE
4. If I wanted to help my children get fewer cavities, I would give them popcorn instead of candy as a snack.
 1. TRUE
 - or
 2. FALSE
5. Baby teeth don't need to be treated by a dentist because permanent teeth are going to come in anyway.
 1. TRUE
 - or
 2. FALSE
6. Children really need to go to the dentist only when they have a problem.
 1. TRUE
 - or
 2. FALSE
7. There is no correct way to brush your teeth, it's just important to do it.
 1. TRUE
 - or
 2. FALSE
8. Parents should brush their children's teeth until they are 5 years old.
 1. TRUE
 - or
 2. FALSE
9. It won't hurt my children's teeth if they go to bed with a bottle with milk in it.
 1. TRUE
 - or
 2. FALSE
10. Children and adults get cavities because of germs in the mouth.
 1. TRUE
 - or
 2. FALSE

B Dental Knowledge score _____

DENTAL DIET SURVEY