CORNWALL DENTAL ARTS
FAMILY AND COSMETIC DENTISTRY
DR. STEVEN J. DENEKA

Welcome to our Practice!

Will you please help us by providing us with the following confidential information?

PARENT INFORMATION:

Last Name: _____ First Name: _____Preferred Name: _____

Street Address: _____ City, Province, Postal Code: _____

Date of Birth:_____ Email Address: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Sex: Male_____ Female_____ Occupation: _____

Employer: _____ Address:_____

Emergency Contact Name: _____ Phone #: _____

In the event that we must contact you for scheduling changes, etc, please indicate the BEST PHONE NUMBER during business hours to phone you:

Phone number: _____

How did you hear about our office? Please check: _____Internet ____Patient referral ____Website ____Yellow Pages ___Mailer Other_____

If you were referred, whom may we thank for their trust in us? _____

INSURANCE INFORMATION: (YES_____ NONE_____)

Primary Insurance Company_____ Group# or Policy #_____

Policy Holder Name: _____Member's ID#: _____ Birth date: _____

Secondary Insurance Company_____ Group# or Policy #_____

Policy Holder Name: _____Member's ID#: _____ Birth date: _____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. I understand that my dental insurance is a contract between me and my insurance carrier and not **between Dr. Steven Deneka Dentistry Professional Corporation and my insurance company.**
All professional services are charged directly to the patient and patients are personally responsible for payment of their accounts. We will prepare any necessary forms or reports to help you collect your benefits from your insurance company.

Date:_____ Patient's Signature _____

CONSENT:

I hereby authorize Dr. Steven Deneka Dentistry Professional Corporation to take the necessary X-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs. I also authorize Dr. Steven Deneka Dentistry Professional Corporation to perform all forms of treatment, medication and therapy that is agreed to be necessary or advisable. I also understand the use of anesthetic agents embodies a certain risk.

I fully understand that it is my financial responsibility for all dental treatment provided, regardless of insurance coverage, and understand that complete payment will be made after each treatment. We accept cash, Debit, Visa, and MasterCard.

Appointment times are reserved for you and we require 48 hours notice (2 business days) notice if you are required to change an appointment. A fee may be charged for cancelled or missed appointments without sufficient notice.

Signature: _____ Relationship to Child : _____Date: _____

Reviewed by Doctor: _____Date:_____

CHILD'S INFORMATION

Child's name_____
First Last Nickname

Age_____ Date of Birth _____ Male_____ Female_____
Day/Month/Year

Child's Favorite toys, sports or activities_____

How do you expect your child to react to his/her visit today?
Excellent Good Fair Poor Don't Know

MEDICAL HISTORY

Child's Physician/Pediatrician _____Phone#_____

Is your child in good health? Yes No

Is your child presently under the care of a physician for any medical reason? Yes No

If yes, please explain_____

Has your child ever been hospitalized or had surgery? Yes No

If yes, please explain_____

Is your child currently taking any medications? Yes No

If yes, please specify_____

Does your child have any allergies or reacted to any of the following? No Yes (Please list)

Aspirin	Pollen/Dust	Local Anesthetics	Penicillin or other antibiotics
Food	Dyes	Latex	Metals

Other, please list_____

Has your child ever been diagnosed as having any of the following conditions? No Yes (Please list)

Yes No Asthma	Yes No Developmentally Delayed	Yes No Hepatitis or liver diseases
Yes No Autism	Yes No Diabetes	Yes No HIV/AIDs
Yes No Acid Reflux /Gerd	Yes No Disabilities/Handicap	Yes No Hyperactivity ADD/ADHD
Yes No Blood disorders	Yes No Down Syndrome	Yes No Kidney Problems
Yes No Bone or joint problems	Yes No Eating Disorders	Yes No Oral ulcers
Yes No Cancer /Tumour	Yes No Eye Problems	Yes No Premature Birth
Yes No Cerebral Palsy	Yes No Emotional Disturbance	Yes No Sickle cell anemia
Yes No Chronic Ear Infections	Yes No Headaches	Yes No Spina Bifida
Yes No Cleft lip/palate	Yes No Hearing/Speech Impairment	Yes No Hemophilia
Yes No Congenital Heart Disease	Yes No Heart Murmur	Yes No Epilepsy or Seizures
Yes No Heart Surgery	Yes No High or Low Blood Pressure	Other _____

Have you ever been told by a physician or a dentist that your child needs to be pre medicated with antibiotics prior to any dental treatment? Yes No

Parent or Guardian Initial _____

DENTAL HISTORY

Reason for today's visit_____

_____

Is this your child's first dental visit? Yes No

If no, date of last visit and dentist's name_____

Has your child been followed by a dentist on a regular basis? Yes No

If yes, since what age_____

Has your child had any unfavorable dental or medical experience in the past? Yes No

If yes, please explain_____

Has your child ever had orthodontic treatment? Yes No If yes are they: still in treatment Yes No treatment completed Yes No

Is your child wearing: Braces: Yes No Removable Appliance: Yes No Fixed Appliance: Yes No

Has your child ever suffered any injuries to his/her teeth, face or mouth? Yes No

If yes, please describe when , where and how_____

Does your child have any of the following habits?

Lip Sucking
Mouth Breathing
Thumb/Finger Sucking/Pacifier
Nail Biting
Snoring
Teeth Grinding
Still Nursing: Breast If not, until what age?_____
Baby Bottle -If not until what age?_____

Has your child had dental pain recently? Yes No

If yes, please explain_____

DIETARY & HYGIENE HISTORY

How often does your child brush his/her teeth?_____

Does your child use: regular tooth brush electric tooth brush

Is tooth brushing : supervised done by parent parents help out Child prefers to brush their own teeth

What type of toothpaste is your child using? _____ Fluoride or non Fluoride toothpaste_____

Is dental floss used? Yes No

Does your child use a fluoride rinse? _____

Does your child snack often? Yes No

Usual type of snack foods and/or drinks:_____

_____

What does your child use to drink: Bottle Sippy Cup Cup

Parent or Guardian Signature: _____ Date:_____

Doctor Signature:_____ Date:_____