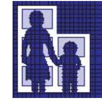
Pediatric Dentistry
Dr. W.P. Loeppky -Dentistry for Children



Pediatric Dentistry Medical/Dental History

The questions are of great value in aiding us better to understand your child.
Please complete each question on BOTH SIDES of this form. All answers are kept in strict confidence.

Alberta Health Care # of Child: ______________________

Childs Full Name: ______________________ Usually Called: ______________

Age: _____ Date of Birth: ______________ ☐ Male ☐Female Place of Birth: ______________

Home#: ______________ Cell #: ______________ School: ______________ Grade: _____

Address: ____

City: ______________________ Prov: __________ Postal Code: ______________

Siblings (Name and Age): ____

Fathers Name: ______________________________ Cell #: ______________

Employed: ______________________________ Phone #: ______________

Residence Address ☐ Same as child or Address: ______________________________

City: ______________________ Prov: __________ Postal Code: ______________

Mothers Name: ______________________________ Cell #: ______________

Employed: ______________________________ Phone #: ______________

Residence Address ☐ Same as child or Address: ______________________________

City: ______________________ Prov: __________ Postal Code: ______________

Whom may we thank for this referral: ______________________________________

Dental Insurance

Father: Date of Birth: ______________ **Mother:** Date of Birth: ______________

Insurance Co: ______________ Insurance Co: ______________

Cert or ID: ______________ Cert or ID: ______________

Group Policy: ______________ Group Policy: ______________

Indian Affairs Band Name & Individual Number: ______________________________________

Alberta Child Health Benefit #: ______________________________________

Dental History

1. Has your child had previous dental treatment? ☐Yes ☐ No If yes, how long ago? ______________________
2. Has your child ever had an unpleasant dental experience? ☐Yes ☐ No If yes, explain: ______________________
   ____
3. Have there been any injuries or trauma to the head, teeth or mouth? ☐Yes ☐ No If yes, explain: ______________
   ____
4. Has your child ever received local anesthetic? ☐Yes ☐ No If yes, explain: ______________________
   ____

(Please turn over)

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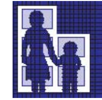

Dental Disease Prevention

1. How often do you brush your child's teeth?

   ☐ very seldom ☐ morning ☐ after eating any food ☐ right after meals ☐ before going to bed
2. Do you floss your child's teeth? ☐Yes ☐ No
3. Has your child received fluoride of any sort?

   ☐ Applications to teeth ☐ Dietary supplements ☐ Fluoride Rinses
4. Does your child take a vitamin supplement? ☐Yes ☐ No If yes, what brand? ________________________________
5. How was your child fed as an infant? ☐ breast ☐ bottle Age weaned: ________________________________
6. Does/Did your child ever have any of the following? **(Please circle those that apply)**

   THUMB/FINGER SUCKING LIP BITING MOUTH BREATHING COLD SORES SNORING

   TONGUE THRUSTING BOTTLE IN BED TEETH GRINDING PACIFIER USE

Medical History

1. Is your child under care of a physician at present? ☐Yes ☐ No

   If yes, since when and why? ________________________________
2. Physician's name ________________________________ Phone # ________________________
3. Has your child ever had a serious illness or been hospitalized? ☐Yes ☐ No

   If yes, please explain: ________________________________
4. Is your child receiving medication? ☐Yes ☐ No

   If yes, what? ________________________________
5. Does your child have limitations to physical activities? ☐Yes ☐ No

   If yes, please explain: ________________________________
6. Were there any problems during pregnancy or delivery? ☐Yes ☐ No

   If yes, please explain: ________________________________
7. Does your child have problems:

   ☐Concentrating ☐Learning ☐Cooperating ☐Understanding ☐Socializing ☐Speech
8. Does your child have AIDS or has he/she tested HIV positive? ☐Yes ☐ No
9. Have you ever been told that your child has any of the following conditions? **(Please circle those that apply)**

KIDNEY PROBLEMS	AUTISM	EPILEPSY	CEREBRAL PALSY	HYPERACTIVITY	CANCER
PHYSICAL HANDICAP	HEADACHES	FAINTING	SCARLET FEVER	PNEUMONIA	ANEMIA
NUTRITIONAL DEFICIENCY	LIVER PROBLEMS	ARTHRITIS	LEUKEMIA	BLOOD TRANSFUSIONS	BRAIN INJURY
DEVELOPMENTAL DELAY	LUNG PROBLEMS	HEPATITIS	DIABETES	PSYCHIATRIC CARE	SEIZURES
HIGH BLOOD PRESSURE	HEART TROUBLE	ANOREXIA	BULIMIA	HEMOPHILIA	CHICKEN POX
EMOTIONAL DISORDERS	TUBERCULOSIS	ASTHMA	BIRTH DEFECTS	SICKLE CELL ANEMIA	CLEFT LIP/PALATE
MALIGNANT HYPERTHERMIA					

ALLERGIES (PLEASE LIST): ________________________________

OTHER/EXPLANATION: ________________________________

FAMILY MEDICAL HISTORY: ________________________________

Consent to Treatment

It is necessary that a signed permission be obtained from a parent or guardian before any and/or all necessary dental services can be started because your child is a minor. Authorization is herby granted as such. If during the course of such treatment, in Dr. Barsky's or Dr. Loeppky's opinion and judgment, any treatment or procedure different that now contemplated should be indicated in respect of which there is no reasonable opportunity for additional explanation and authorization, you further request and authorize him to do whatever he considers advisable. Furthermore, you will be responsible for any account incurred on this child for dental treatment and understand that the account is due at each appointment, or whatever previous arrangement has been decided upon with Dr. Barsky or Dr. Loeppky.

If applicable, I hereby authorize release to my insuring company plan administrator, the information contained in claims submitted electronically and hereby assign my benefits payable from claims submitted electronically to Dr. Barsky or Dr. Loeppky and authorize payment to him.

Date: ________________________________ **Signed**: ________________________________

We would like to thank you for spending the time in filling out this form.

Dr. Barsky/Dr. Loeppky