32 PEARLS
DENTAL

Confidential Patient Record Child

Name:_____
Last First Middle

Birth Date:_____ NS Health Card #:_____
Day/Month/Year

Parents/Guardians:_____

Address:_____
Street City Province Postal Code

Telephone: Home:_____ Parent/Guardian Work:_____

Parent/Guardian Cell:_____ Would you like a text reminder for Appointments: YES/NO

Email:_____ Would you like an email reminder for your appointments: YES/NO

Physician:_____ Telephone:_____

In case of emergency Call: _____ Telephone:_____

Dental Insurance: Yes/No *Please give card to front desk*

How did you hear about us? _____

Medical and Dental History

	YES	NO
Has your child ever had a serious illness or ever treated for any medical conditions currently?.....	☐	☐
Is your child taking any medications now?/ever?.....	☐	☐
Has your child ever had an unpleasant anesthetic (freezing) experience or reaction to drug?	☐	☐
Has your child been warned against taking any specific medication? (Penicillin).....	☐	☐
Have you child been hospitalized?.....	☐	☐

Any Allergies or medications: _____

Office Policy

Your appointment time will be reserved especially for you. If you are unable to keep this appointment, please provide **AT LEAST 48 HOURS NOTICE**, otherwise there will be a charge for the time lost. We appreciate your consideration of this policy. I understand as the patient or guardian of the above patient, responsible to my dentist for services rendered to my account.

Permit of Operations

I, the undersigned, certify that all of the above medical & dental information is true to my knowledge and that I have not omitted any pertinent information. I consent to the performing of dental procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated. Possible complications of treatment have been explained to my satisfaction. I will assume responsibility for fees associated with these procedures.

Patient (Parent/Guardian) Signature:_____ Date:_____

Dentist signature:_____ Date:_____