Patient Information

Children Below 18 Years of Age

Dr. Derek Haruta and Associates
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Email: info@drharuta.com

Date: _____

Your cooperation in filling out the data on the confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with this office.

Child's Full Name (last/first/middle) _____

Nickname _____ School _____

Age _____ Date of Birth (dd/mm/yyyy) _____ Sex _____

Favourite Toy _____ Favourite Sport _____

Parent's / Guardian's Full Names _____

Address _____

Postal Code _____ Home Phone _____ Cell Phone _____

Brothers' & Sisters' Names and Ages _____

Person Responsible for Account Name (First + Last Name) _____

Address _____

Postal Code _____ Phone _____

Employed By _____ Occupation _____

Dental Insurance Type: ☐ No insurance ☐ Private Insurance ☐ Healthy Smiles # _____

☐ C.A.S ☐ Other _____

Insurance Company _____ Policy No. _____ Certificate/I.D # _____

Family Physician _____ City _____ Phone _____

Pharmacy _____ City _____

Previous Dentist _____ Phone _____

Whom may we thank for referring you _____

In Case of Emergency Notify (Name): _____

Address _____

Relationship _____ Phone _____

Are You Seeking Treatment For Any Particular Reason and/or Routine Dental Care?

_____

Other Comments _____

Confidential Medical History

When did your child last visit the physician? _____

Reason _____

Has your child ever had any serious illness or been in the hospital? ☐YES ☐NO

If yes, describe _____

Does your child have any known medical, physical or mental handicaps? ☐YES ☐NO

If yes, describe _____

Has your child ever had or been tested positive for any immunocompromising disease? ☐YES ☐NO

If yes to any of the above, describe _____

Has your child have/had rheumatic fever? ☐YES ☐NO

Has your child have/had heart disease or murmur? ☐YES ☐NO

Is your child allergic to anything? ☐YES ☐NO

If yes, describe _____

Does he or she bruise easily or bleed profusely for a long period of time? ☐YES ☐NO

Does your child have/had any blood disease? ☐YES ☐NO

Does your child have/had any emotional problems? ☐YES ☐NO

Is your child now taking, or has taken or had taken:
☐Penicillin ☐Other Antibiotics ☐Cortisone ☐Local Anaesthesia ☐General Anaesthesia

☐ Other drugs _____

Has he or she had any unfavourable reaction to these drugs? ☐YES ☐NO

Is there a history of any inherited diseases in the family? ☐YES ☐NO

If yes, describe _____

Has your child ever had any of the following? Please check all that apply.

☐ Measles
☐ Kidney Disease
☐ Lung Disease
☐ Adenoids
☐ Ear Trouble
☐ Asthma
☐ Operations
☐ Liver Disease
☐ Ankle Swelling
☐ Gland Trouble
☐ Broken Bones
☐ Chest Pains
☐ Heart Trouble
☐ Mumps
☐ Scarlet Fever
☐ Tonsils
☐ Abnormal Blood Pressure
☐ Nervous Disorder
☐ Shortness of Breath
☐ Tuberculosis
☐ Jaundice
☐ Epilepsy
☐ Fainting Spell
☐ Rheumatic Fever
☐ Strep Throat
☐ Hay Fever
☐ Chicken Pox
☐ Diabetes
☐ Other _____

Dental History

Has your child had previous dental care? ☐YES ☐NO

If Yes, When? _____

Has he or she ever had an unpleasant experience associated with dental treatments? ☐YES ☐NO

If yes, describe _____

Is there a family history of: (Check, if YES)

☐High decay rate ☐Spaced teeth ☐Extra teeth ☐Cleft lip/or palate ☐Tooth deformity
☐Missing teeth ☐Crooked teeth ☐ Gum disease

If yes, describe _____

Does your child have any oral habits such as: (Check, if YES)

☐Thumb sucking ☐Lip Biting ☐Tongue Thrusting ☐Mouth Breathing ☐Chewing (e.g.Pencils)
☐Finger sucking ☐Nail Biting ☐Teeth Grinding

Office Policy

Insurance claims can be sent on your behalf to your insurance provider if the company allows it; however, we do not direct bill. Therefore, payments for services are due at the time of each appointment. Your appointment time is especially reserved for you. If you cannot keep the appointment, we require a minimum of 24 hours' notice. If we are not notified, you will be charged for that lost time. Overdue accounts will be subject to interest and collection charges.

Consent for Treatment

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable including the use of local or general anaesthetic as indicated and I will assume responsibility for fees associated with those procedures. I authorize this office to contact my previous dentist, medical doctor(s), Insurance Company, plan administrative at work and share Information as needed. As well as submit insurance claims electronically.

Parent/Guardian Signature _____ Date _____