RIX ORTHODONTICS
natural healthy smiles

Child patient information and medical history

Please complete this form with your child's information and history.
Please check or circle **only** those that apply.

Child's Full Name: _____
Date of Birth: _____ Age: _____ Gender: Male ___ Female ___
Family dentist: _____ Referred by: _____
Physician: _____ Alberta Health Care number: _____
Name(s) of other family members being treated at our office: _____

Mother's name: Ms/Mrs/Miss/Dr _____ Email: _____
Phone #: Cell _____ Home _____ Business _____
Address: _____ City: _____ Postal Code: _____
Child lives at this address: Full- time _____ Part-time _____ None of the time _____ Other _____
Insurance information: Insurance Company _____ Employer: _____
Group/Policy #: _____ ID/Certificate #: _____ Date of Birth: _____

Father's name: Mr/Dr _____ Email: _____
Phone #: Cell _____ Home _____ Business _____
Address: _____ City: _____ Postal Code: _____
Child lives at this address: Full- time _____ Part-time _____ None of the time _____ Other _____
Insurance information: Insurance Company _____ Employer: _____
Group/Policy #: _____ ID/Certificate #: _____ Date of Birth: _____

Guardian's name (if applicable): _____ relationship to child _____
Phone #: Cell _____ Home _____ Business _____
Address: _____ City: _____ Postal Code: _____
Child lives at this address: Full- time _____ Part-time _____ None of the time _____ Other _____
Insurance information: Insurance Company _____ Employer: _____
Group/Policy #: _____ ID/Certificate #: _____ Date of Birth: _____

MEDICAL HISTORY:
Check any of the following health concerns, past or present

□ ADD/ADHD	□ Bleeding Disorder	□ Heart condition/stroke	□ Rheumatic Fever
□ AIDS/HIV	□ Cancer Treatment	□ Hepatitis/Jaundice	□ Seizures/Epilepsy
□ Anxiety Disorder	□ COVID-19	□ Kidney Disease	□ Sleep Apnea
□ Arthritis	□ Depression	□ Liver Disease	□ Thyroid
□ Asthma	□ Diabetes	□ Mitral valve prolapse	□ Tuberculosis

□ Other_____

____ My child is in good health.
____ My child is under a physician's care. Please explain: _____
____ My child is on medications. Please specify: _____
____ My child has been required to take antibiotics prior to receiving dental treatment.
Please specify: _____

My child has or has had:
_____ frequent respiratory infections
_____ frequent ear infections
_____ tubes in the ears
_____ enlarged tonsils or adenoids
_____ tonsils or adenoids removed. When? _____
_____ allergies. Please specify: _____
_____ digestive problems. Please specify: _____

DENTAL HISTORY:
Check any of the following that your child has experienced

□ Jaw Discomfort □ Tooth Grinding □ Jaw Clicking
□ Tooth Clenching □ Jaw Locking □ Frequent Headaches

_____ My child has had injuries/trauma to the face, mouth, or teeth.
Please specify: _____
_____ My child is missing or has extra primary (baby) and/or permanent (adult) teeth?
Please specify: _____
_____ My child has had primary (baby) and/or permanent (adult) teeth extracted by a dentist.
Please specify: _____

PREGNANCY/BIRTH HISTORY:

My child's birth was:
_____ premature _____ full term _____ c-section
Please specify any complications with the pregnancy or your child's birth: _____

INFANT/CHILD DEVELOPMENT:

My child:
_____ was breast fed. For how long? _____
Please specify any difficulties with breastfeeding: _____
_____ was bottle fed. For how long? _____
_____ used a pacifier/soother
_____ used a sippy cup
At what age did your child start eating soft food? _____ solid food? _____
_____ has or had a tongue tie. Please specify: _____
My child:
_____ is a slow eater
_____ is a fast eater
_____ is a noisy eater
_____ chews with an open mouth
_____ tears food into tiny pieces
_____ needs to drink constantly when eating solid food
_____ has difficulty with certain food textures. Please specify: _____
_____
_____ eats one food at a time
_____ doesn't let different foods touch each other
_____ has trouble licking ice cream cones
_____ has trouble swallowing in general. Please specify: _____
_____ has trouble swallowing pills. Please specify: _____
_____ has jaw joint or facial pain when eating certain foods. Please specify: _____

BREATHING:

My child:

_____ has trouble breathing through the nose
_____ has been assessed by an ENT specialist. Please specify: _____
_____ lives with a pet cat and/or dog
_____ breathes through the mouth during the day
_____ breathes through the mouth during the night
_____ drools while sleeping
_____ often has a "stuffy" nose
_____ often has the mouth open when watching TV, reading, or using electronic devices
_____ usually has the lips closed
_____ usually has the lips apart
_____ usually has dry or chapped lips
_____ chronically licks the lips

SPEECH:

My child:

_____ has problems with speech or creating certain sounds.
Please specify: _____
_____ has had speech therapy. Please specify: _____

HABITS:

My child:

_____ sucks or has sucked a thumb or finger(s). Until what age? _____
_____ sucks or has sucked on a blanket. Until what age? _____
_____ bites or has bitten their nails. Until what age? _____
_____ bites or has bitten their lips. Until what age? _____
_____ sucks or has sucked their lips. Until what age? _____
_____ has been a gum chewer
_____ has or had a habit of chewing on pencils/pens
_____ has or had some other sucking/biting habit. Please specify: _____
_____ plays a musical instrument. Please specify: _____
_____ participates in organized sports. Please specify: _____
_____ participates in organized dance classes. Please specify: _____
_____ also participates in……. Please specify: _____

SUPPLEMENTAL QUESTIONS:

What is/are the reason(s) for seeking orthodontic treatment?
Please specify: _____
_____ My child has had previous orthodontic evaluations.
_____ My child has had previous orthodontic treatment.
Please specify: _____
Is there any dental work to be done at your family dentist?
Please specify: _____
When was your child's last dental checkup? _____

PARENT'S/GUARDIAN'S SIGNATURE:_____ **Date:** _____

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PEDIATRIC SLEEP QUESTIONNAIRE

PATIENT NAME _____ DATE _____ DATE OF BIRTH _____

Please complete this form as accurately as you can. Feel free to use information you have gathered from others, including other family members, caregivers, friends, or teachers. Dr. Rix understands that orthodontic treatment is just one component of a person's overall health. He will work with you to manage your child's sleep and breathing problems as part of their orthodontic care.

Please answer the following questions as they pertain to your child in the past month. (DK=Don't Know)

1.	**While sleeping does your child:**			
	Snore more than half the time?	Yes	No	DK
	Always snore?	Yes	No	DK
	Snore loudly?	Yes	No	DK
	Have "heavy" or loud breathing?	Yes	No	DK
	Have trouble breathing, or struggle to breathe?	Yes	No	DK
2.	**Have you ever seen your child stop breathing during the night?**	Yes	No	DK
3.	**Does your child:**			
	Tend to breathe through the mouth during the day?	Yes	No	DK
	Have a dry mouth upon waking in the morning?	Yes	No	DK
	Occasionally wet the bed?	Yes	No	DK
4.	**Does your child:**			
	Wake up feeling unrefreshed in the morning?	Yes	No	DK
	Have a problem with sleepiness during the day?	Yes	No	DK
5.	**Has a teacher or supervisor commented that your child appears sleepy during the day?**	Yes	No	DK
6.	**Is it hard to wake your child up in the morning?**	Yes	No	DK
7.	**Does your child wake up with headaches in the morning?**	Yes	No	DK
8.	**Did your child stop growing at a normal rate at any time since birth?**	Yes	No	DK
9.	**Is your child overweight?**	Yes	No	DK
10.	**Your child often:**			
	Does not seem to listen when spoken to directly.	Yes	No	DK
	Has difficulty organizing tasks and activities.	Yes	No	DK
	Is easily distracted by extraneous stimuli.	Yes	No	DK
	Fidgets with hands or feet or squirms in seat.	Yes	No	DK
	Is "on the go" or often acts as if "driven by a motor".	Yes	No	DK
	Interrupts or intrudes on others (eg. Butts into conversations or games).	Yes	No	DK
11.	**Does your child:**			
	Take a long time to fall asleep?	Yes	No	DK
	Have difficulty staying asleep?	Yes	No	DK
	Snore occasionally?	Yes	No	DK
	Frequently wet the bed?	Yes	No	DK
	Breathe through the mouth during sleep?	Yes	No	DK
	Sleep on his/her side?	Yes	No	DK
	Sleep on his/her back?	Yes	No	DK
	Sleep on his/her front?	Yes	No	DK
	Frequently become cranky, easily upset or emotional?	Yes	No	DK
	Experience night terrors, sleep walking, sleep talking?	Yes	No	DK
	Sleep with his/her neck extended?	Yes	No	DK
	Experience night sweating?	Yes	No	DK

12. Your child gets approximately _____ hours of sleep each night.

Rix Orthodontics

Dental Office Personal Information Consent Form

We are committed to protecting the privacy of our patient's personal information and to utilize all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use, and disclose. In addition to the circumstances described in this form, we also collect, use, and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers, cell phone numbers, and e-mail addresses (collectively referred to as "Contact Information"). Contact information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
- Financial information may be collected in order to make arrangements for the payment of dental services.
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further dental examination or treatment.
- To send patients informational material about our practice.

Contact Information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement for payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition, and dental treatments (collectively referred to as "Medical Information"). Patient's Medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment. Patient's Medical Information is disclosed:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.
- To other dentists and dental specialists where we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment.

We collect Patient's Diagnostic Records (photographs, radiographs (x-rays), and study models) for the purpose of formulating a complete diagnosis. Patient's Diagnostic Records:

- May be used for educational and training purposes as reference material in an educational setting with other dental or medical professionals.
- All personal information (ie. last names) relating the diagnostic records to a specific patient will be removed.

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process, to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College, which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

I consent to the collection, use and disclosure of my and/or my child's personal information as set out above.

*Print name of child (if applicable)*_____

_____	_____	_____
Date	*Print Name (of Parent and/or Guardian)*	*Signature*