

CANYON GLOW DENTAL

CHILD / PEDIATRIC NEW PATIENT FORM

Welcome! Please complete this form so we can provide safe, comfortable, and personalized dental care for your child.

CHILD INFORMATION

Child's Full Name: _____ Preferred Name / Nickname: _____
Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female ☐ Prefer not to say
Home Address: _____
City: _____ State: _____ ZIP: _____
School: _____ Grade: _____

PARENT / LEGAL GUARDIAN

Parent / Guardian Name: _____ Relationship to Child: _____
Phone: _____ Email: _____
Second Parent / Guardian: _____ Phone: _____
Who may authorize dental treatment for this child? _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

DENTAL INSURANCE

Does your child have dental insurance? ☐ Yes ☐ No
Insurance Company: _____ Subscriber Name: _____
Subscriber DOB: _____ Member / ID #: _____ Group #: _____
Relationship of Subscriber to Child: _____
Secondary Dental Insurance: ☐ Yes ☐ No If yes: _____

PAYMENT PREFERENCE

How would you prefer to take care of your child's dental care?
☐ Dental Insurance ☐ Cash / Credit / Debit Card
☐ Canyon Glow Dental Membership Plan ☐ CareCredit / Third-Party Financing
☐ Other: _____

YOUR CHILD'S DENTAL HISTORY

Is this your child's first dental visit? ☐ Yes ☐ No
Previous Dentist: _____ Approximate Date of Last Visit: _____
What brings your child in today? _____

Please check any concern that applies:

- | | |
|--|---|
| ☐ Toothache or dental pain | ☐ Sensitive teeth |
| ☐ Cavities | ☐ Broken or chipped tooth |
| ☐ Swollen or bleeding gums | ☐ Bad breath |
| ☐ Grinding or clenching | ☐ Difficulty chewing |
| ☐ Crowded or crooked teeth | ☐ Thumb or finger sucking |
| ☐ Pacifier use | ☐ Mouth breathing |
| ☐ Snoring | ☐ Previous dental injury or trauma |
| ☐ Concern about tooth appearance or color | ☐ Other: _____ |

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DENTAL HABITS

How often does your child brush? ☐ Twice daily ☐ Once daily ☐ Occasionally
Who usually brushes your child's teeth? ☐ Child independently ☐ Parent/guardian helps ☐ Parent/guardian brushes
Does your child floss? ☐ Daily ☐ Sometimes ☐ Not yet
Does your child use fluoride toothpaste? ☐ Yes ☐ No ☐ Unsure
Does your child frequently drink sugary beverages? ☐ Yes ☐ No
Does your child take a bottle or sippy cup to bed? ☐ Yes ☐ No

COMFORT PREFERENCES

Help us make your child's visit as comfortable as possible. Please check anything that applies.

- | | |
|---|--|
| ☐ This is my child's first dental experience | ☐ My child is nervous or afraid of the dentist |
| ☐ Please explain things before treatment | ☐ My child does better with simple explanations |
| ☐ My child gags easily | ☐ My child has sensitive teeth |
| ☐ My child does not like shots | ☐ My child is bothered by the sound of the dental drill |
| ☐ My child is sensitive to bright lights or loud noises | ☐ My child may need extra time to become comfortable |
| ☐ My child has had a difficult dental experience in the past | ☐ I would like to remain with my child when appropriate |
| ☐ Other: _____ | |

MEDICAL HISTORY

Child's Pediatrician / Physician: _____ Phone: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No
If yes, please explain:

Is your child currently taking any medications? ☐ Yes ☐ No
If yes, please list medication(s) and reason:

Does your child have any medication, food, latex, or other allergies? ☐ Yes ☐ No
If yes, please list allergy and reaction:

Has your child ever been hospitalized or had surgery? ☐ Yes ☐ No
If yes, please explain:

Please check any condition that applies:

- | | |
|---|--|
| ☐ Asthma | ☐ Allergies |
| ☐ Heart condition / heart murmur | ☐ Diabetes |
| ☐ Seizures / epilepsy | ☐ Bleeding or clotting disorder |
| ☐ Anemia | ☐ Kidney condition |
| ☐ Liver condition | ☐ Respiratory condition |
| ☐ Sleep apnea or sleep concerns | ☐ Developmental delay |
| ☐ Autism spectrum disorder | ☐ ADHD |
| ☐ Sensory processing concerns | ☐ Anxiety |
| ☐ Physical disability | ☐ Premature birth |
| ☐ Other: _____ | |

Has your child ever been advised to take antibiotics before dental treatment? ☐ Yes ☐ No ☐ Unsure

Is there anything else we should know about your child's health, behavior, development, or comfort?

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HOW DID YOU HEAR ABOUT US?

- | | |
|---|---|
| ☐ Family or Friend | ☐ Google |
| ☐ Dental Insurance | ☐ Social Media |
| ☐ Saw Our Office | ☐ Current Canyon Glow Dental Patient |
| ☐ Other: _____ | |

Referral name, if applicable: _____

PARENT / GUARDIAN ACKNOWLEDGMENT

I certify that the information provided on this form is complete and accurate to the best of my knowledge. I understand that it is my responsibility to inform Canyon Glow Dental of any changes to my child's health, medications, allergies, dental insurance, or contact information.

Parent / Guardian Name: _____

Signature: _____

Date: _____

Thank you for choosing Canyon Glow Dental.
We look forward to making your child's visit comfortable, positive, and full of smiles.