UBC DENTISTRY

THE UNIVERSITY OF BRITISH COLUMBIA

I request that my son/daughter be registered in the Children's Dental Program to be held at UBC. I consent to my child receiving routine dental treatment. **I understand that treatment will be provided by a <u>dental student</u> ("dentist and or dental hygienist in training") under the supervision of a faculty member of UBC Faculty of Dentistry**. However, if the supervising faculty member feels that the treatment is beyond the scope of a dental student, my son/daughter will be referred for treatment to the UBC Graduate Specialty Program in Pediatric Dentistry. Treatment in the graduate program will be provided by a dentist who is taking extra training in children's dentistry. Fees will be charged for treatment in the graduate program and I must arrange transportation.

I understand that treatment may include x-rays, preventive procedures (teeth cleaning, fluoride treatment, dental sealants), silver fillings, silver caps, tooth coloured fillings, extractions (tooth pulling), root canals on baby teeth, and the use of local anaesthetic (freezing).

PLEASE PRINT

Child's Name: **Last name** **First name**		Male □ Female ☐	
Address:		City:	Postal Code:
Home Phone:	Email address:	Birthdate: **Year** **Month** **Day**	Age:
Name of parent or guardian: Mother ☐ Father ☐ **Last name** **First name**			
Primary Contact Person:		Primary contact home phone or cell number:	
Family Doctor:	Dr's Phone:	Care Card #:	
Child's School:	Division:	Grade:	
Language Spoken at Home:	Translator:	Translator's Phone Number:	
Have you applied for the Canada Dental Care Plan? Yes □ No ☐		To learn more, please scan the QR code or visit canada.ca/dental	

Please describe your concern: _____

Although UBC will make every effort to complete all treatment your child needs, any treatment <u>not</u> completed is the responsibility of the parent or guardian. Please go to your family dentist for completion of unfinished treatment.

Return Completed – Signed Form To:

Christine Cromarty, CDA
Abbotsford Public Health Unit
104-34194 Marshall Rd Abbotsford V2S 5E4
P: 604 864-3420 F:604 864.3410
christine.cromarty@fraserhealth.ca

Please complete the other side

PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FOR YOUR CHILD

1.	Has your child been a patient in a hospital during the past 2 years? If yes, please explain:	Yes □ No □
2.	Has your child been under the care of a physician during the past 2 years for other than regular, routine checkups? If yes, please explain:	Yes □ No □
3.	Has your child taken any kind of medicine or drugs during the past year? If yes, please explain:	Yes □ No □
4.	Does your child have any allergies? If yes, please explain:	Yes □ No □
5.	Does your child have any known heart disease? E.g. Heart murmur If yes, please explain:	Yes □ No □
6.	Does your child have chest pain upon exertion? If yes, specify:	Yes □ No □
7.	Is your child ever short of breath after mild exercise? If yes, specify:	Yes □ No □
8.	Has your child ever been told his/her blood pressure is high or low? If yes, specify:	Yes □ No □
9.	Has your child ever been told he/she has kidney disease? If yes, specify:	Yes □ No □
10.	Has your child ever had hepatitis, jaundice or liver disease? If yes, specify:	Yes □ No □
11.	Does your child have a blood disorder? E.g. anaemia If yes, specify:	Yes □ No □
12.	Has your child ever bled heavily after having a tooth removed? If yes, specify:	Yes □ No □
13.	Does your child bruise or bleed easily? If yes, specify:	Yes □ No □
14.	Has your child ever had an unexpected response to medicines or injections? E.g. local anaesthetic (freezing for dental work) If yes, specify:	Yes □ No □
15.	Is there anything else you would like us to know about your child? Specify:	Yes □ No □

I declare that the information above is true and accurate to the best of my knowledge and that our family does not have any private insurance for necessary dental care. I also understand that my child's provincial Care Card number will be used to check his/her eligibility for the Healthy Kids Dental program. My family may be contacted for dental health counselling or for telephone follow-up.

_____ _____

Signature of Parent or Guardian Date