New Patient Registration – Minors Date: _____

Patient Information			
First Name	Last Name	Middle Initial	Date of Birth / Age

Legal Guardian Information			
First Name	Last Name	Relationship to Minor	
Address	City	Province	Postal Code
Email Address		Phone Number	

Medical History	
Within the last 3 years, has the minor been hospitalized or had surgery?	☐ Yes ☐ No
If yes, please give details and dates:	
Is the minor currently taking any medications?	☐ Yes ☐ No
If yes, please list medications and amounts:	
If the minor has *any* allergies, please list and describe:	
Please list any medical problems or conditions that should be brought to our attention: _____	
Is this the first visit to a dentist?	☐ Yes ☐ No
On a scale of 1 (minor) to 10 (extreme), how anxious has your child been at previous dental appointments? _____	
Please note – Despite our best efforts, some minor patients do not respond well, and are uncooperative, to dental treatment. Since we value the time of all our patients, we can only spend so much time before we decide to end treatment. A referral to a pediatric dentist/specialist will be provided in most circumstances.	
Present dental concerns: _____	

Consent to treat a minor – To the best of my knowledge, all of the above information is correct and complete. I also consent Island Roots Dental to contact other healthcare or insurance providers on the minor's behalf, and to have health and contact information released for referrals or to aid in any care and treatment. I also consent to diagnosis and treatment performed as recommended by Island Roots Dental.

I am legally authorized to provide medical/dental consent for: _____ (minor's name).

Guardian Signature: _____ Date: _____

Reviewed By: _____ Date: _____