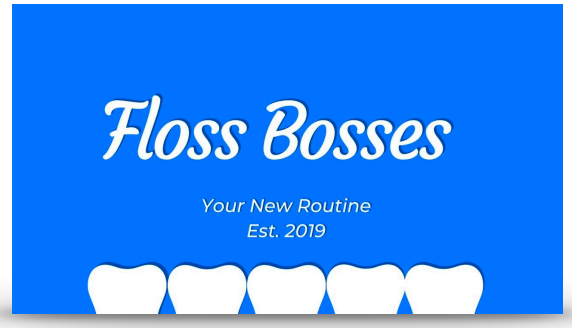

FLOSS BOSSES
Phone number: (825)-901-GUMS(4867)
Address: #207, 6958 76 AVE NW
Edmonton, AB T6B 2R2
Email: info@flossbosses.ca

Please fill out the following to enrol your child

Child's name: _____ Date of birth: _____

Address: _____ Postal Code: _____

City/Province: _____

PARENT/LEGAL GUARDIAN INFORMATION:

Parent/legal guardian name: _____

Address: _____ Postal Code: _____ City/Province: _____

CONTACT INFORMATION

- Cell phone number: _____
- Secondary contact number: _____
- Home phone number: _____

Please check mark primary number to contact in the circle

Email address: _____

Please circle preferred method of contact: SMS CALL EMAIL

Best time to contact: _____

MEDICAL INFORMATION

Child's diagnosis/suspected diagnosis: _____

Describe the nature of your child's disability: _____
_____
_____

Date of diagnosis: _____

Are they currently taking any medications? YES / NO

If yes, what medications? _____
_____

Has your child ever had seizures? YES / NO

Describe the type of seizure: _____

Allergies: _____
_____

Does your child wear a hear aid? YES / NO

Any other physical challenges that the dental team should be aware of?
_____
_____
_____

ORAL CARE

Describe your child's at-home dental care: _____
_____
_____
_____

Does your child use / please circle:

Electric toothbrush or manual toothbrush

Does your child floss? YES / NO

When it comes to their at-home dental care are they: independent or require assistance

Has your child visited the dentist before? YES / NO

Last dental check up: _____ Last dental cleaning: _____

How was the child's past experience at the dental office? _____
_____
_____
_____

Best time to see child: _____

What are your dental health goals for your child? _____
_____
_____
_____

COMMUNICATION & BEHAVIOUR

Is your child verbal / non-verbal

Are there certain cues that might help the dental team? _____
_____
_____

Useful phrases or words that work best with your child? _____
_____
_____

Will you be bringing a communication system with you? YES / NO

Are there any symbols/signs that we can have available to assist with communication?
_____

Please list any specific behavioural challenges that you would like the dental team to be aware of: _____
_____
_____

Feel free to bring objects that are comforting for your child to any dental visit.

SENSORY ISSUES

Please list any specific sounds that your child is sensitive to: _____
_____

Does your child prefer the quiet? YES / NO

Is your child more comfortable in a dimly lit room? YES / NO

Is your child sensitive to motion and moving? (Ie. the dental chair moving up and down or reclining?) YES / NO

Any other movements your child will be sensitive to? _____
_____

Does your child have any specific oral sensitivities (ie. gagging, gum sensitives etc)

_____

Does your child experience sensitivity to:

HOT / COLD / SWEETS

Do certain tastes bother your child? YES / NO

Please list: _____

Any additional information you would like to provide that you feel would be important for us to know? _____

_____

_____

_____

Thank you for filling out the following forms. Once the forms have been filled out please either take a picture or scan it and have the following forms sent to:

Email: info@flossbosses.ca

Fax number: (587)-882-7724

If you have any other questions please contact us by calling (825)-901-GUMS(4867)