Your Health & Comfort is Our Happiness

PATIENT INFORMATION
CHILDREN'S HISTORY

DATE: ___________________________

CHILD'S FULL NAME: ____
FIRST MIDDLE LAST

AGE______ DATE OF BIRTH (MM/DD/YY) ____/____/____ SEX M F HOME PHONE _________________________

ADDRESS ____
NO. & STREET APT/UNIT CITY PROV POSTAL CODE

DENTAL INSURANCE YES NO

Insured's Name_____________________________________ Insured's Date of Birth (MM/DD/YY) _____/_____/_____

Insured's Employer __________________________________ Insurance Company_____________________________

Insurance Policy No. _________________________________ I.D. or Certificate No. ____________________________

PERSON RESPONSIBLE FOR ACCOUNT ____

FAMILY PHYSICIAN ____PHONE # ___________________________

WHOM MAY WE THANK FOR REFERRING YOU? ____

IN CASE OF EMERGENCY NOTIFY

Name: ____ Relationship _______________________________________

Home Phone # __________________________________ Cell #____

CHILD'S HISTORY

NICKNAME _________________________________ _____USUALLY CALLED _________________________________

SIBLINGS NAMES & AGES ____

FAVOURITE SPORT _________________________________ FAVOURITE PERSON ______________________________

ARE YOU SEEKING TREATMENT FOR ANY PARTCUAL REASON AND/ OR ROUTINE DENTAL CARE?

____

CONFIDENTIAL MEDICAL HISTORY

When did your child last visit the physician? ____

Reason ____

Has your child ever had any serious illness or been in the hospital? YES NO

If so, describe ____

Has your child ever had any of the following?

☐ Mumps	☐ Fainting Spells	☐ Strep Throat	☐ Nervous Disorder	☐ Broken Bones
☐ Abnormal Blood Pressure	☐ Measles	☐ Adenoid Problems	☐ Operations	☐ Chest Pains
☐ Kidney Disease	☐ Ear Troubles	☐ Liver Disease	☐ Tonsils	☐ Chicken Pox
☐ Heart Trouble	☐ Asthma	☐ Hay Fever	☐ A.I.D.S.	☐ Tuberculosis
☐ Lung Disease	☐ Shortness of breath	☐ Ankle Swelling	☐ Diabetes	☐ Epilepsy
☐ Jaundice	☐ Other ______________			

If yes to any of the above, describe ____

Is your child allergic to anything? YES NO

If so, please list ____

Does your child bruise easily or bleed heavily for a long period of time? YES NO
Does your child have any blood disease? YES NO
Does your child have any emotional problems? YES NO
Is your child now taking, or has taken:
☐ Penicillin ☐ Other Antibiotics ☐ Cortisone ☐ Local or General Anaesthesia ☐ Other Drugs ____________

Has your child had any unfavourable reactions to any drugs? If so what are they __________________ YES NO
Is there a history of any inherited diseases in the family? YES NO
If so, describe ____

CONIDENTIAL DENTAL HISTORY

Has your child had previous dental care? YES NO When ____
Has your child ever had any unpleasant experience associated with dental treatment? If yes describe ____________ YES NO
Is there a history of any inherited diseases in the family? If yes, describe ____________________________ YES NO
Has your child ever had orthodontic treatment? If yes when______________________________________ YES NO
Has your child ever had any accidents, injury or surgery about the mouth? YES NO
If yes, describe____

Is there a family history of:

☐ High decay rate ☐ Missing teeth ☐ Cleft lip and or palate
☐ Tooth deformity ☐ Extra teeth ☐ Gum disease
☐ Spaced Teeth ☐ Crooked teeth ☐ Discoloured teeth

If yes, describe ____
Is your child's sugar intake: ☐ HIGH ☐ MEDIUM ☐ LOW

How often does your child brush their teeth? ____
Do you supervise the child while tooth brushing? YES NO
Has your child ever received oral hygiene including tooth brushing instructions
from a dentist or dental hygienist? YES NO
Has your child ever received fluoride supplements in the diet or water supply? YES NO
Were his/her teeth ever treated with decay-preventing topical fluorides? YES NO
Are you interested in a tooth decay prevention program for your child? YES NO

ADDITIONAL INFORMATION

If there is any specific problem regarding your child's oral health which concerns you, or if there is any additional information which you feel may be helpful in our care of your child, please state: ____

CONSENT FOR TREATMENT

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable for the named child including the use of local anaesthetic and or nitrous gas as indicated and I will assume responsibility for fees associated with those procedures. I also consent to the child's physician or medical specialist being contacted if necessary. I understand that this information is necessary to provide optimum dental care.

____ Date ____________________________________
Parent or Guardian Signature Month Day Year

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