

WELCOME TO OUR DENTAL OFFICE

Date _____

I.D. #
Medical Alert Yes <input type="checkbox"/> No <input type="checkbox"/>

General Dental Health Questionnaire

The data on this confidential questionnaire is essential in performing the highest standard of pediatric dental care for your child. We would appreciate your co-operation in carefully filling out this form so that we will have accurate records on your child.

Child's Information:

Name: _____ Birthdate: _____

First Last

Nickname: _____ Sex: ___ Age: _____ Grade: _____

Names and ages of siblings: _____

Who is responsible for making appointments? _____

Daytime Phone Number to Confirm/Schedule Appointments: _____

Parent/Guardian Information:

Name: _____ Relationship: _____

First Last

Address _____

Street City Province Postal Code

Date of Birth: _____ Home Tel: () _____ Work Tel: () _____

Name: _____ Relationship: _____

First Last

Address _____

Street City Province Postal Code

Date of Birth: _____ Home Tel: () _____ Work Tel: () _____

Email Address: _____

Write phone number(s) we may routinely use to contact you _____

Family Physician/Pediatrician: _____ Tel:() _____

Family Dentist or child's former Dentist: _____ Tel:() _____

Who may we thank for referring you to our office? _____

Financial Information

Primary Insurance

Policy Holder: _____

Ins. Company: _____ Tel:() _____

Employer: _____ Ins. Yr.End: _____

Policy #: _____ Certificate #: _____ ID/SIN #: _____

Max Cov: _____ %Coverage for: _____ Basic _____ Maj.Restorative _____ Orthodontic

Secondary Insurance

Policy Holder: _____

Ins. Company: _____ Tel:() _____

Employer: _____ Ins. Yr.End: _____

Policy #: _____ Certificate #: _____ ID/SIN #: _____

Max Cov: _____ %Coverage for: _____ Basic _____ Maj.Restorative _____ Orthodontic

Medical History

Date: _____

When did your child last visit the physician? _____

Reason _____

Has your child ever had any serious illness or been in the hospital? _____

If so, describe _____

Does your child have any known medical, physical, or mental handicaps? _____

If so, describe _____

Did the mother have any problems during pregnancy or delivery? _____

If so, describe _____

Has your child ever had any of the following? If yes, please check appropriate boxes and enter date.

Heart Issue _____ Mumps _____ Hay Fever _____ Jaundice _____ Hepatitis _____

Liver Disease _____ Abnormal Blood Pressure _____ Kidney Disease _____ Rheumatic Fever _____ Scarlet Fever _____

Lung Disease _____ Diabetes _____ Asthma _____ Tonsils _____ Tuberculosis _____

Gland Issue _____ Epilepsy _____ Nervous Disorders _____ Broken Bones _____ Strep Throat _____

Operations _____ Adenoids _____ Measles _____ Epilepsy _____ Chicken Pox _____

Ear Issue _____ Malignant _____ Physical _____ Other _____ None _____

Hyperthermia Deformity

If so, please describe _____

Is your child allergic to anything? _____

If so, describe _____

Does your child bruise easily or bleed profusely for a long period of time? _____

Does your child have any blood disease? _____

Is your child now taking any medication, or has he/she ever had: _____

Penicillin _____ Other Antibiotics _____ Cortisone _____ Local Anaesthesia _____

General Anaesthesia _____ Other Drugs _____

Has your child had any unfavorable reaction to these drugs? _____

Is there a history of any inherited diseases in the family? _____

Please describe any medical problems not listed above: _____

Dental History

Has your child had previous dental care? _____ When? _____

Has he or she ever had an unpleasant experience associated with dental treatment? _____

If so, describe _____

Has your child ever had an accident, injury or surgery about the mouth? _____

Is there a family history of: (check if yes)

High decay rate Missing teeth Cleft lip/or palate Tooth deformity

Extra teeth Spaced teeth Crooked teeth Other

If so, describe _____

Does your child have any oral habits such as : (check if yes)

Thumbsucking Nail biting Chewing (e.g. pencils) Fingersucking

Mouth breathing Lip biting Teeth grinding Other

If so, describe _____

Has your child ever had any orthodontic treatment? _____

How often does your child brush his or her teeth? _____

Do you supervise the child while toothbrushing? _____

Has your child ever received fluoride supplements in the diet or water supply? _____

Were his or her teeth ever treated with decay-preventing topical fluorides? _____

General Release

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health cared provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

Parent/Guardian Signature _____