(For Office Use Only)

I.D. #
Medical Alert Yes ☐ No ☐

WELCOME TO OUR DENTAL OFFICE

Date_____

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 Presure _____ ☐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 everhad:_____
Penicillin ____ Other Antibiotics _____Cortisone_____ Local Anaesthesia _____
General Anaethesia _____ 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 _____