TODAY'S DATE_____

# Child's Medical History Questionnaire

**Welcome to our office. The following information is required to enable us to provide your child with the best possible dental care. All information is strictly private and is protected by doctor-patient confidentiality. Please ask if you wish to review our Privacy Policy. The dentist will review the information and our staff will help you complete the form if necessary. Please complete both sides of the questionnaire.**

Child's Name: _____ Date of Birth_____Sex_____

Mother: Name_____ Father: Name_____

P.O. Box #_____ R.R. #_____ P.O. Box # _____ R.R. #_____

Street # _____ Street # _____

Town/Prov _____Postal Code_____ Town/Prov. _____Postal Code_____

Telephone: home_____work_____ Telephone:home_____work_____

Employer_____ Employer_____

Whom do we notify in case of emergency?_____Telephone:_____

Child's Medical Doctors: G.P._____ Specialist(s)_____
& phone number Health Card #_____

Child's school_____ present grade_____

Who referred you to our practice? _____

Do you have dental benefits? ____ Group _____Policy Number_____

**Please answer the following questions with a "yes", "no", or "not sure" and/or provide details as required**.

1. Is the child being treated for ***any*** medical condition or have they been treated within the past year? _____If so, provide details
_____

2. When was the child's last medical checkup?_____

3. Has there been any change in general health in the last year? _____ If yes, please explain
_____

4. Is the child taking ***any*** medications, non-prescription drugs or supplements, or herbal remedies? ___☐___ If yes, please list:
_____

5. Does the child have ***any*** allergies or had a peculiar or adverse reaction to any medication or injection? ___☐___ If yes, explain:
_____

Is the child allergic to ***Penicillin*** ☐ or ***Latex/rubber*** ☐?

6. Do you feel that this child cares for his or her teeth well? ___☐___ If not, explain: _____
_____

***Please Complete the other side of this form***

7. Does the child have or have he or she had <u>any</u> of the following? Please circle ***<u>any</u>*** which apply .

Heart problems :angina ___ heart attack ___ murmur, mitral valve prolapse, or rheumatic fever _____

prosthetic heart valve ___ pacemaker ___ cardiac bypass ___ other _____

Bloodpressure: High ___ Low ___ Stroke ___ Bleeding problems _____ Blood disorders ___ other___

Lung disease: Asthma ___ Shortness of breath ___ tuberculosis ___ emphysema ___ other ___

Cancer ___ Steroid Therapy ___ Radiation Therapy ___ Chemotherapy ___ Arthritis ___ Diabetes ___

Stomach ulcers ___ other Gastro-intestinal disease ___ Kidney disease ___ Thyroid disease ___

Hepatitis or jaundice ___ other Liver disease ___AIDS/HIV ___ Seizures or Epilepsy _____

other Neurological disease or disorder ___ Mental illness ___ _____Drug/Alcohol dependency_____

8. Are there any other conditions or diseases that the child has or has had ? _____ If yes, please provide details:
_____

9. Have you ever been advised by your doctor to have this child take an antibiotic before dental treatment? _____ If so, why? _____

10. When was the child's last dental visit? _____ Name of the last dentist _____

11. Are you aware of problems this child may have or have had related to any of the following:

Gums ___ Chewing ___ Swelling ___ Pain or sensitivity ___ Tooth decay ___ Jaw joints ___

Broken teeth ___ Missing Teeth ___ Bad breath ___ Appearance ___ Mouth Sores ___

12. Is the child nervous about dental treatment? ___ If so, what in particular?_____

13. Has the child had specialist dental treatment such as orthodontics or paediatric dentistry?
_____

14. Briefly describe the reason for your visit today._____

_____

## <u>Consent to Dental Treatment for a Minor Child</u>

**I hereby state that I am the parent and/or legal guardian of _____ consent to the rendering of dental treatment and oral surgical procedures deemed necessary and/or advisable for this child. This includes radiographs (x-rays), local anaesthetic (freezing), and conscious sedation (nitrous oxide). I assume full responsibility for professional and laboratory fees and costs incurred and understand that these fees and costs are due and payable at the time of service. <u>*I understand that a fee will be charged for broken or failed appointments when at least 24 hours notice is not provided.*</u>**

**Date_____ Signature of Parent or Guardian_____**