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## Patient Information : Health & Dental History

Patient: First Name: _____ Last Name: _____

Home Phone _____

Name child likes to be called _____ Birthdate _____ Age _____ Sex _____

Address _____ Apt/Suite _____

City _____ Province _____ Postal Code _____

School /Grade _____

Child's Health Card # _____

Child's Interests ( favourite toy, movie, etc.) _____

Names and ages of other children in family _____

Mother _____ Employer _____

Birthdate _____ Work Phone _____

Email Address _____ Cell Phone _____

Father _____ Employer _____

Birthdate _____ Work Phone _____

Email Address _____ Cell Phone _____

Who has Legal Custody of the patient ? _____

How did you hear about our office? _____

Please check if your child is having problems with any of the following:

- ☐ Cavities
- ☐ Surgical Mouth Treatment
- ☐ Orthodontics
- ☐ Toothache
- ☐ Gum Infections
- ☐ Jaw Sounds
- ☐ Sensitive Teeth
- ☐ Discolouration of Teeth
- ☐ Healthy Check Up
- ☐ Other

Additional Comments : _____

## Dental Insurance Information

Primary Policy Holder _____

Name _____

Date of Birth _____

Employer of Insured _____

Insurance Carrier _____

Group Policy # _____

Subscriber ID # _____

Secondary Policy Holder _____

Name _____

Date of Birth _____

Employer of Insured _____

Insurance Carrier _____

Group Policy # _____

Subscriber ID # _____

## Health History

Patient: First Name _____ Last Name _____

☐ Yes ☐ No Is your child in good health? Date of last physical exam _____

Name of child's Physician _____

☐ Yes ☐ No Are your child's immunizations up-to-date? _____

☐ Yes ☐ No Has your child had any operations? _____

☐ Yes ☐ No Is your child taking any Mediations? _____

Please list mediation(s), dose(s) and reason(s): _____

☐ Yes ☐ No Were there any problems at birth? _____

☐ Yes ☐ No Is your child allergic to anything? _____

Please check if your child has been diagnosed, treated or is being treated for any of the following:

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV | ☐ Speech / Hearing Problems | ☐ Epilepsy / Seizures | ☐ Psychiatric Care | ☐ Heart Condition / Murmur |
| ☐ Asthma | ☐ Blood Disorder | ☐ Kidney Disease | ☐ Rheumatic Fever | ☐ Liver Disease/ Hepatitis |
| ☐ Autism | ☐ Excessive Bleeding | ☐ Frequent Headaches | ☐ Behavior Issues | ☐ LD Learning Disabilities |
| ☐ ADD/ADHD | ☐ Congenital Birth Defects | ☐ Cancer / Tumors | ☐ Tuberculosis | ☐ Other |
| ☐ Diabetes | ☐ Frequent Infections | ☐ Stomach / GI Disease | ☐ Cerebral Palsy | |

Please elaborate on any item checked: _____

Was your child: ☐ Breast Fed ☐ Bottle Fed At what age was it stopped? _____

## Dental History

☐ Yes ☐ No Has your child ever been to the dentist? Date of last visit. _____

Name of Dentist _____

☐ Yes ☐ No Has your child ever had Dental X-rays? Date _____

☐ Yes ☐ No Do you think your child will react well to dental treatment? If not, explain: _____

☐ Yes ☐ No Has your child ever sucked a finger, thumb or pacifier? Ages when? _____

☐ Yes ☐ No Does your child brush his/her own teeth? How Often? _____

☐ Yes ☐ No Do you or your child use Dental Floss? How often? _____

☐ Yes ☐ No Does your child use a Fluoride Toothpaste?

☐ Yes ☐ No Does your child have snacks between meals?

☐ Yes ☐ No Have your child's teeth ever been injured? When? Which teeth? _____

Treatment? _____

☐ Yes ☐ No Does your child's jaw make noise and is pain associated with the sounds?

☐ Yes ☐ No Is your child a Mouth Breather?

☐ Yes ☐ No Does your child grind their teeth? During the day? ☐ During the night? ☐

Comments: _____

Signature: _____ Date _____

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