



Certified Specialist in Children's Dentistry

416 224-2300

106 Sheppard Avenue West
Toronto, ON, M2N 1M5

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:

- | | | | |
|---|---|--|--------------------------------|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Toothache | <input type="checkbox"/> Sensitive Teeth | <input type="checkbox"/> Other |
| <input type="checkbox"/> Surgical Mouth Treatment | <input type="checkbox"/> Gum Infections | <input type="checkbox"/> Discolouration of Teeth | |
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Jaw Sounds | <input type="checkbox"/> Healthy Check Up | |

Additional Comments : _____

Dental Insurance Information

Primary Policy Holder _____ Secondary Policy Holder _____

Name _____ Name _____

Date of Birth _____ Date of Birth _____

Employer of Insured _____ Employer of Insured _____

Insurance Carrier _____ Insurance Carrier _____

Group Policy # _____ Group Policy # _____

Subscriber ID # _____ 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:

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