

**White Oaks Mall
Dental Clinic**

**PATIENT INFORMATION
CHILDREN'S HISTORY**

DATE _____

CHILD'S FULL NAME _____

LAST FIRST MIDDLE

AGE _____ SEX _____ HOME PHONE # _____

ADDRESS _____
No. & STREET CITY PROV/State POSTAL CODE /zip

DATE OF BIRTH _____ DENTAL INSURANCE No Yes -
DAY MONTH YEAR

Name of Insurance Company _____

Insurance Policy No. _____ I.D. or Certificate No. _____

% COVERED _____ HEALTH INSURANCE No. _____

FAMILY PHYSICIAN _____ PHONE No. _____

PREVIOUS DENTIST _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IN CASE OF EMERGENCY NOTIFY: Name _____

Address _____

Relationship _____ Telephone _____

PERSON RESPONSIBLE FOR ACCOUNT _____

DRIVER'S LICENCE No. _____

Parent's Name _____ Phone No. _____

Parent's Employer _____ Phone No. _____

CHILD'S HISTORY

NICKNAME _____ USUALLY CALLED _____

DATE OF BIRTH _____ SCHOOL _____

SIBLINGS NAMES & AGES _____

FAVOURITE SPORT _____ FAVOURITE PERSON _____

ARE YOU SEEKING TREATMENT FOR ANY PARTICULAR REASON AND/OR ROUTINE
DENTAL CARE? _____

OTHER COMMENTS _____

CONFIDENTIAL MEDICAL HISTORY

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 _____

Has your child ever had any of the following?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Adenoid Problems | <input type="checkbox"/> Operations | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ear Trouble | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Physical Deformity |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Asthma | <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> A.I.D.S. |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Gland Trouble | |

If yes to any of the above, describe _____

Is your child allergic to anything? _____

If yes, describe _____

Does he or she bruise easily or bleed heavily for a long period of time? _____

Does your child have any blood disease? _____

Does your child have any emotional problems? _____

Is your child now taking, or has he or she had: Penicillin Other Antibiotics

Cortisone Local or General Anaesthesia Other drugs _____

Has he/she had any unfavourable reaction to any drugs? _____

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

If yes, describe _____

CONFIDENTIAL DENTAL HISTORY

Has your child had previous dental care? NO YES When? _____

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

If yes, describe _____

Has your child ever had orthodontic treatment? _____

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

Is there a family history of: high decay rate missing teeth cleft lip and/or palate
 tooth deformity extra teeth gum disease
 spaced teeth crooked teeth discolored teeth

If yes, describe _____

Does your child have any oral habits such as:

thumbsucking lip biting teeth grinding tongue thrusting
 fingersucking mouth breathing (frequently) chewing (e.g.- pencils) other

If yes, describe _____

Is your child's sugar intake: HIGH MEDIUM LOW

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

Do you supervise the child while toothbrushing? _____

Has your child ever received oral hygiene including toothbrushing instruction from a dentist or a dental hygienist? _____

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

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

Are you interested in a tooth decay preventive program for this child? _____

ADDITIONAL INFORMATION

If there is any specific problem regarding your child's oral health which concerns you, or if there is any additional information which you feel may be helpful in our care of your child, please state: _____

CONSENT FOR TREATMENT

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable for the named child including the use of local anaesthetic and/or nitrous gas as indicated and I will assume responsibility for fees associated with those procedures. I also consent to the child's physician or medical specialist being contacted if necessary. I understand that this information is necessary to provide optimum dental care.

Parent or Guardian Signature _____

DATE _____ month _____ day _____ year