

# PATIENT INFORMATION - CHILD

<b>PATIENT CODE</b> _____	
<b>GROUP</b> _____	<b>CH#</b> _____

<b>MEDICAL-DENTAL ALERT</b> _____
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## PERSONAL INFORMATION

Today's Date \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Sex: M F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SIN: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

Mailing/Home Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician/Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's Former Dentist: \_\_\_\_\_

Name of Personal Responsible for this Account / Card Holder: \_\_\_\_\_

<b>FATHER'S DENTAL INSURANCE COMPANY</b>
Employer: _____
Business Address: _____
Phone: _____
Insurance Co.: _____
Policyholder Name: _____
Policyholder DOB: _____
Policy/Group No.: _____
ID#: _____
Dept./Class: _____
Certificate #: _____
Alberta Health Care # _____

<b>MOTHER'S DENTAL INSURANCE COMPANY</b>
Employer: _____
Business Address: _____
Phone: _____
Insurance Co.: _____
Policyholder Name: _____
Policyholder DOB: _____
Policy/Group No.: _____
ID#: _____
Dept./Class: _____
Certificate #: _____
Alberta Health Care # _____

## CHILD'S HISTORY

School Attended: \_\_\_\_\_ Hobbies/Sports: \_\_\_\_\_

Brothers' & Sisters' Names and Ages \_\_\_\_\_

Favourite Toy: \_\_\_\_\_ Favourite Person: \_\_\_\_\_

Are you seeking treatment for any particular reasons and/or routine dental care? \_\_\_\_\_

## MEDICAL HISTORY

When did your child last visit the Physician/Pediatrician? \_\_\_\_\_

Reason: \_\_\_\_\_

Has your child ever had any serious illness or been hospitalized? \_\_\_\_\_

If so, please describe: \_\_\_\_\_

Does your child have any known medical, physical or mental handicaps? \_\_\_\_\_

If so, please describe: \_\_\_\_\_

Has your child had any of the following?:

- Y N**
- Measles
  - Mumps
  - Chicken Pox
  - Scarlet Fever
  - Strep Throat
  - Tonsils Removed
  - Adenoids Removed
  - Ear Trouble

- Y N**
- Asthma
  - Hay Fever
  - Heart Trouble
  - Rheumatic Fever
  - Chest Pains
  - Fainting/Seizures/Epilepsy
  - Ankle Swelling
  - Abnormal Blood Pressure

- Y N**
- Shortness of Breath
  - Lung Disease
  - Tuberculosis
  - Nervous Disorder
  - Epilepsy
  - Liver Disease
  - Jaundice

- Y N**
- Kidney Disease
  - Diabetes
  - Gland Trouble
  - Broken Bones
  - Operations
  - Physical Deformity
  - OTHER

If yes to any of the above, please describe: \_\_\_\_\_  
\_\_\_\_\_

Is your child allergic to anything? \_\_\_\_\_

Does he/she bruise easily or bleed profusely for a long period of time? \_\_\_\_\_

Does your child have any blood disease? \_\_\_\_\_

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

Penicillin: \_\_\_\_\_ Other Antibiotics \_\_\_\_\_ Cortisone \_\_\_\_\_

Local Anaesthesia \_\_\_\_\_ General Anaesthesia: \_\_\_\_\_ Other Drugs \_\_\_\_\_

Has he or she had any unfavourable reaction to any drug? \_\_\_\_\_

Is there a history or any inherited diseases in the family? \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

### DENTAL HISTORY

Has your child had previous dental care? \_\_\_\_\_ When? \_\_\_\_\_

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

If yes, please describe \_\_\_\_\_

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

If yes, please describe: \_\_\_\_\_

Is there a family history of:

**Y N**

High decay rate

Tooth Deformity

Extra Teeth

Cleft lip / or palate

**Y N**

Missing Teeth

Spaced Teeth

Crooked Teeth

Gum Disease

If yes, please describe: \_\_\_\_\_

Does your child have any oral habits such as:

**Y N**

Thumbsucking

Lip Biting

Mouth Breathing

Chewing (e.g. pencils)

**Y N**

Fingersucking

Nail Biting

Teeth Grinding

Tongue Thrusting

If yes, please describe: \_\_\_\_\_

Has your child ever had orthodontic treatment? \_\_\_\_\_

How often does your child brush his/her teeth? \_\_\_\_\_

Do you supervise the child while toothbrushing? \_\_\_\_\_

Has your child ever received oral hygiene or 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? \_\_\_\_\_

Have you ever received a dental consultation on your children's diet? \_\_\_\_\_

Are you interested in a caries (dental decay) preventive program for your 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 describe below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE CHECK OVER AND UPDATE INFORMATION WITH A DIFFERENT COLOURED PEN, TO ENSURE THAT ALL INFORMATION IS CURRENT AND CORRECT. PLEASE SIGN BELOW.

1. Date \_\_\_\_\_ Signature \_\_\_\_\_

2. Date \_\_\_\_\_ Signature \_\_\_\_\_

3. Date \_\_\_\_\_ Signature \_\_\_\_\_

4. Date \_\_\_\_\_ Signature \_\_\_\_\_

