

PEDIATRIC MEDICAL AND DENTAL HISTORY

CAREFUL COMPLETION OF THIS FORM WILL ASSIST US IN PROVIDING YOUR CHILD WITH THE BEST POSSIBLE DENTAL CARE.

Patient Information:

Date: _____, 20____

Name: _____ Male Female

Prefers to be called: _____ Date of Birth: _____ / _____ / _____ Home phone #: _____
(Day) (Month) (Year)

Mother's Name: _____ Employer: _____ Work #: _____ Cell #: _____

Father's Name: _____ Employer: _____ Work #: _____ Cell #: _____

Civic Address: _____ Mailing Address: _____

City: _____ Province: _____ Postal Code: _____

E-Mail Address (optional): _____

School: _____ Grade: _____

Child's Favourite Hobbies: _____

Names and ages of siblings: _____

Whom may we thank for referring you? _____

Emergency contact: _____ Relationship: _____ Phone #(s) _____

Insurance Information:

Insurance Company: _____ Policy Number: _____ ID: _____

Health Card Number: _____ Expiry Date: _____

Medical History:

Child's Physician: _____ Phone : _____

Date of last Physical Examination: _____

Is your child being treated by a physician at this time? Yes No

If yes, why? _____

Is your child taking any medications at this time? Yes No

If yes, what and why? _____

Has your child ever been hospitalized? Yes No If yes, why and when? _____

Has your child had any operations? Yes No If yes, why and when? _____

Has your child ever been sedated or received general anesthetic? Yes No If yes, any complications? _____

Is your child allergic to anything (Medications, Foods, Latex, Metals, Dyes, Other) Yes No

If yes, what? _____

Has your child ever been given antibiotics? Yes No If yes, were there any complications? _____

Has your child EVER had any treatment for any of the following?

Blood-circulatory Yes No Gastrointestinal Yes No Musculoskeletal Yes No

Bones Yes No Heart Yes No Nervous System Yes No

Endocrine Glands Yes No Kidney / Bladder Yes No Skin Yes No

Eyes, Ears, Nose, Throat Yes No Liver Yes No

If yes to any of the above, please elaborate: _____

Has your child ever been diagnosed as having any of the following conditions?

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Learning Disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nutritional Deficiency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Excess Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Autism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Brain Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tetanus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cerebral Palsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis – Type ____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other: _____		
Cleft Lip/Palate	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Immune Deficiency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Premedication needed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cystic Fibrosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reason: _____		

Dental History:

Is this your child's first dental visit? Yes No
 If no, how long has it been? _____ Name of previous dentist: _____

Has your child had any problems with dental treatment in the past? Yes No
 Has your child had dental radiographs (x-rays)? Yes No If yes, when were they last taken? _____
 Has your child ever had local anesthetic (freezing)? Yes No If yes, were there any complications? Yes No
 Have there been any injuries to teeth, such as falls, blows, chips, etc.? Yes No
 If yes, describe: _____

Does your child grind his / her teeth? Yes No
 Does his / her jaw crack or pop? Yes No

Please indicate if your child has or has had any of the following oral habits:

Breathes through mouth Yes No Bottle to bed Yes No
 Sucks thumb or finger Yes No Headaches Yes No
 Uses a pacifier Yes No If yes, until what age? _____ Tongue habit Yes No If yes, until what age? _____
 Nail biting Yes No If yes, until what age? _____ Other: _____ Until what age? _____
 Does your child use any fluoride supplements? Yes No
 How often does your child brush his / her teeth? _____ When? _____
 Type of toothbrush: manual, powered, soft or hard bristles _____
 Does your child floss his / her teeth? Yes No When? _____
 Is there assistance or supervision when: Brushing? Yes No Flossing? Yes No
 Family history of missing or extra teeth? _____
 Any other information you feel would benefit us to better treat your child: _____

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

 Parent signature (or Guardian) Date / /

I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and I will assume responsibility for fees associated with these procedures, including fees for failed or missed appointments.

 Parent signature (or Guardian) Date / /

I hereby authorize release, to my insuring company plans administrator and CDA, information contained in claims submitted electronically and for the communication of information related to the coverage of services described to **SouthWest Dental Surgeons Ltd.** This authorization shall continue in effect until the undersigned revokes the same.

I hereby assign my benefits payable from claims submitted electronically to **SouthWest Dental Surgeons Ltd.** and authorize payment directly to it. This authorization shall continue in effect until the undersigned revokes the same.

 Signature of Subscriber
 Date: _____, 20____.

 Signature of Subscriber
 Date: _____, 20____.