MEDICAL DENTAL HISTORY - CHILD

Please fill out the form below

MEDICAL/DENTAL HISTORY FORM - PEDODONTIC-CHILD

Last Name | Initial | First Name

Address | City | Postal

Home Tel | Cell | Work

Date of Birth: DD/MM/YYYY | Email Address

Emergency Contact | Phone

Person Responsible for Child's account | Health Card #

Do you have dental insurance? ○ Yes ○ No

If Yes complete the following

Primary Insurance

Company | Policy Holder

Policy/Plan/Group | Certificate/I.D.

Policy holders Date of Birth DD/MM/YYYY | Relation to Holder

Secondary Insurance

Company | Policy Holder

Policy/Plan/Group | Certificate/I.D.

Policy holders Date of Birth DD/MM/YYYY | Relation to Holder

Has there been any change in your childs general health? ○ Yes ○ No

If YES please describe

Are you being treated for any medical condition or have you been treated within the past 2 years? ○ Yes ○ No

If YES please describe

Are you currently being treated by a physician for a specific condition? ○ Yes ○ No

If YES please describe

Are your currently taking any medication? ○ Yes ○ No

If YES please describe | Dose

If YES please describe | Dose

If YES please describe | Dose

Does your child have any allergies? ○ Yes ○ No

If YES please describe

Do you bleed or bruise easily? ○ Yes ○ No

Have you ever been hospitalized? ○ Yes ○ No

If YES please describe

Has your child ever received general anesthesia? ○ Yes ○ No

Has your child ever had an adverse reaction to local anesthetic? ○ Yes ○ No

Does your child have any other allergies? ○ Yes ○ No

If YES please list

Does your child currently have any of the following conditions?

☐ Heart Murmur	☐ Joint replacement	☐ Osteoporosis	☐ Rheumatic Fever	☐ Jaundice	☐ AIDS/HIV
☐ Hepatitis A/B	☐ Thyroid Disease	☐ Mental Illness	☐ Diabetes	☐ Heart Attack	☐ High Blood Pressure
☐ Cancer	☐ Arthritis	☐ Epilepsy	☐ Asthma	☐ Liver Disease	☐ Drug/Alcohol Abuse
☐ Kidney Disease	☐ Stroke	☐ Radiation Therapy	☐ Steroid Therapy	☐ Artificial Joint Replacement	

Is there anything else the doctor needs to know regarding your childs medical health? ○ Yes ○ No

If YES please explain

Dental History

Has your child ever been to the dentist before? ○ Yes ○ No

If yes at what age?

Is your child currently experiencing any pain or discomfort? ○ Yes ○ No

Are any of your teeth sensitive to ☐ Cold ☐ Hot ☐ Sweet ☐ Biting

Does your child have difficulty chewing food or does food get stuck between their teeth? ○ Yes ○ No

Has your child ever had an injury to your jaw or face? ○ Yes ○ No

Has your child been examined by an ORTHODONTIST regarding growth patterns and development? ○ Yes ○ No

PATIENT CERTIFICATION AND CONSENT

I the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I will assume full responsibility for the fees associated with these procedures. I agree to the privacy policies posted in the reception area and consent to the electronic sharing of information with my insurance company for the purpose of processing insurance claims and determination of benefits. Unless other arrangements have been made assignment of benefits from your insurance company will be set up. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and my dentist. I authorize the dentist to treat me and I assume full responsibility for all fees. I am aware that 2 business days notice is required to change or cancel an appointment without charge.

______________________________ SIGNATURE (PARENT OR GUARDIAN IF UNDER 16)

To be signed at your appointment