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 you 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: _____

Continued on reverse →

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

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

_____

Signature of Subscriber

Date: _____, 20____.

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____