CHILD & TEEN HEALTH QUESTIONNAIRE

In order to render optimum health care service it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency. Therefore PLEASE ANSWER EVERY QUESTION ON BOTH SIDES. Please feel free to ask the receptionist for help in completing this form.

PERSONAL INFORMATION (Please print) Date_____

Child's Full Name _____ Nick Name _____

Address_____

Postal Code _____ Phone _____

Age _____ Birthdate_____ Birthplace _____

School _____ Grade _____

Whom may we thank for referring you? _____

Father's Name _____ Occupation _____

Employed by _____ Bus. Phone _____

Mother's Name _____ Occupation _____

Employed by _____ Bus. Phone _____

Do you have dental insurance? ❑ Yes ❑ No

Dental Ins. Co. _____ % covered _____

Group No. _____ Cert. or ID No. _____

Name of parent responsible for this account _____

MEDICAL HISTORY

Child's Physician _____ Phone _____

	Yes	No
1. Is child under the care of a physician? If so, explain _____	❑	❑
2. Has child ever had any serious illness or been treated in the hospital? If so, explain _____	❑	❑
3. Is child now taking any medicine? What? _____	❑	❑
4. Is child allergic to any medicine or food List _____	❑	❑
5. Has child ever had any unfavourable reaction to any previous medical or dental care?	❑	❑

6. Has child ever had any of the following conditions? (please ✓ any that apply)

Measles	❑	Shortness of breath	❑	Blood Disease	❑
Mumps	❑	Lung Disease	❑	Diabetes	❑
Chicken Pox	❑	Fainting spells	❑	Epilepsy	❑
Scarlett Fever	❑	Ankle swelling	❑	Jaundice	❑
Strep Throat	❑	Pains in chest	❑	Kidney Disease	❑
Tonsillitis	❑	Heart Trouble	❑	Liver Disease	❑
Ear Aches	❑	Rheumatic Fever	❑	Tuberculosis	❑
Hay fever	❑	Bruise easily	❑	Nervous Disorder	❑
Asthma	❑	Prolonged bleeding	❑	Psychiatric care	❑
Muscular Dystrophy	❑	Multiple Sclerosis	❑	Other major disease	❑
		AIDS or HIV+	❑		

DENTAL HISTORY

		Yes	No
1.	Has child had previous dental care?	❑	❑
	If so, how long ago? _____		
2.	Has child ever had an accident, injury or surgery about the mouth?	❑	❑
	If yes, describe_____		
3.	Has child ever had an unpleasant experience associated with a dental visit?	❑	❑
	If yes, describe_____		
4.	Is the child particularly nervous about visiting the dentist?	❑	❑
5.	Have child's teeth ever been treated with decay-preventing Fluoride?	❑	❑
6.	Has child ever had Orthodontic treatment?	❑	❑
7.	Does child have any oral habits such as:		

Thumb sucking ❑ Nail biting ❑
Finger sucking ❑ Mouth breathing ❑
Lip biting ❑ Teeth grinding ❑
Tongue thrusting ❑ Other _____

Is there a family history of:

High decay rate ❑ Extra teeth ❑
Gum disease ❑ Missing Teeth ❑
Malformed teeth ❑ Crooked Teeth ❑

8. How often does child brush his or her teeth? _____
9. Additional information_____

METHOD OF PAYMENT

If Responsible Party does not currently have an account with this office, please check one of the following:

❑ Payment in full at each appointment
❑ Post-dated cheque for Insured Expenses
❑ Financial arrangements for Non-Insured Expenses (Upon approval)
❑ Visa ❑ Master Card

AUTHORIZATION

I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical and dental histories are correct to the best of my knowledge. I understand that my dental insurance (if insured) is a contract between the insurance carrier and me, and not between the insurance carrier and the dentist, and that I am still responsible for all dental fees. I understand that I will be charged for all dental treatment, and that any payments received by the Dental Office from my insurance company will be credited to my account, or refunded to me if I have paid the dental fees incurred.

PARENT'S CONSENT FOR CHILDREN UNDER 18

I hereby consent to the performing of the Dental and Oral Surgery procedures necessary or advisable for my children, including the use of Local Anaesthesia and / or Relaxitive Analgesia, as indicated, and I accept responsibility for the fee.

Patient Signature _____ Date _____