WELCOME TO THE 404 DENTAL OFFICE

PERSONAL HISTORY

Child's Full Name: _____ Date of Birth (MM/DD/YY): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

E-Mail Address: _____

School: _____

Father's Name: _____ Occupation: _____

Employer: _____ Bus. Phone: _____

Mother's Name: _____ Occupation: _____

Employer: _____ Bus. Phone: _____

Child's Physician: _____ Phone: _____

MEDICAL HISTORY

1. Is the child under the care of a physician now? YES or NO

If yes, explain _____

2. Has your child ever had any serious illness or been hospitalized? YES or NO

If yes, explain _____

3. Is the child taking any medication now? YES or NO Prescription / Non-prescription?

Present Medications: _____

4. Is the child allergic to any medication, food, or environmental factor? YES or NO

Allergies: _____ Do you carry an Epi-Pen? YES or NO

5. Has the child ever had any of the following illnesses or conditions?

☐ Hepatitis	☐ Headaches	☐ Jaundice	☐ Earaches
☐ Diabetes	☐ Lung Disease	☐ Measles	☐ Fainting Spells
☐ Mumps	☐ Rheumatic Fever	☐ Tuberculosis	☐ Bruise Easily
☐ Chicken Pox	☐ Psychiatric Care	☐ Scarlet Fever	☐ Stomach Problems
☐ Epilepsy	☐ Asthma	☐ Tonsilitis	☐ Hay Fever
☐ Kidney Disease	☐ AIDS or HIV	☐ Liver Disease	☐ Eating Disorders
☐ Anaemia	☐ Migraines	☐ Blood Disorders	☐ Mental or Nervous Disease
☐ Genetic Syndromes: _____		☐ Other: _____	
☐ Other: _____		☐ Other: _____	

6. Has the child ever had any heart condition, murmur, or surgery? YES or NO

If yes, explain _____

7. Have you been advised that the child requires antibiotics before any dental work? YES or NO

8. Has the child had any unusual reaction to local / general anaesthetic, or nitrous oxide sedation? YES or NO

9. Does the child have any family history or Malignant Hyperthermia? YES or NO

PLEASE COMPLETE BACK OF FORM ALSO.

DENTAL HISTORY

1. Has the child had previous dental care? YES or NO

If yes, how long ago? _____

2. Has the child had any injury or surgery to his/her face, head, or neck? YES or NO

If yes, describe? _____

3. Has the child ever had any unpleasant experience associated with a dental visit? YES or NO

If yes, describe? _____

4. Has the child had any dental x-rays? YES or NO

If yes, when were they taken? _____

5. Is the child particularly nervous? YES or NO

6. Does the child have any oral habbits such as:

- ☐ Clenching
- ☐ Pacifier
- ☐ Grinding
- ☐ Thumb-sucking
- ☐ Mouth Breathing
- ☐ Toungue Thrusting
- ☐ Nail Biting
- ☐ Other _____

7. Has the child had any orthodontic treatment? YES or NO

8. Has the child had brushing and flossing instructions? YES or NO

9.What does the child's current homecare routine include?

- ☐ Electric brush
- ☐ Flossing
- ☐ Other: _____
- ☐ Manual brush how often- 1 2 3 4 5x/day
- ☐ Parental assistance

10. Do your child's gums bleed with brushing and/or flossing? YES or NO

11. Has your child been complaining of any dental pain? YES or NO

12. Is there a family history of:

- ☐ High Decay Rate
- ☐ Malformed Teeth
- ☐ Extra Teeth
- ☐ Missing Teeth
- ☐ Gum Disease
- ☐ Crowded Teeth

PARENTAL CONSENT for children under the age of 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 Anaesthetic and/or Relative Analgesia as indicated, and I accept respon-sibility for the fee.

Date _____ Parent's Signature _____