# HERITAGE DENTAL CENTRE

Submit Form

## Child Medical / Dental History

Name: _____ Nickname, if any: _____
(FIRST) (MIDDLE) (LAST)

Age: _____ Date of Birth _____ Sex (F) ☐ (M) ☐ Place of Birth: _____
(MONTH) (DAY) (YEAR)

Attends What School: _____ Grade: _____
Name and Age of brothers/sisters: _____
Child's Primary Physician or Pediatrician: _____
Family Dentist: _____
Father (full name): _____ Email:_____
Mother (full name): _____ Email:_____
Home Address: _____ Postal Code: _____ Tel: _____
Father Employed: _____ Tel: _____
(NAME OF PLACE OF EMPLOYMENT) (POSITION)

Mother Employed: _____ Tel: _____
(NAME OF PLACE OF EMPLOYMENT) (POSITION)

Dental Insurance Company: 1. _____ ID/Cert.#: _____ Policy/Group #_____
2. _____ ID/Cert.#: _____ Policy/Group #_____

Which Parent/Guardian will be responsible for payment of this account? _____
If you have previously completed this form for another child, please give that child's name: _____
Whom may we thank for referring you? _____

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## Dental History

What is the reason for this visit? _____
When did this child last receive dental treatment? _____
Has your child had any unfavourable experiences in a dental or medical office? _____
Please Describe:
How would you describe your child's temperament: _____
Does your child have any habits which may affect the teeth or mouth?

Breathes through mouth _____ Sucks thumbs or fingers _____
Pacifier habit _____ Grinds teeth _____
Tongue habit _____ Other _____

Does your child experience pain in the jaws or experience headaches while chewing? _____
How often does your child brush his/her teeth? ____ times/day. When? _____ After each meal? _____
How often does your child floss his/her teeth? _____
Brand of toothpaste used _____
Has your child had fluorides of any sort?

Topical application to teeth _____ How often? _____ Date of last one: _____
Drops or tablets _____ How often? _____ How many? _____

Does your child take a vitamin supplement? ☐ NO ☐ YES
Brand/s _____
Have dental x-rays been taken of this child? ☐ NO ☐ YES When? _____
Where? _____
Does your child tolerate milk and other foods well? ☐ NO ☐ YES

Has your child had any of the following:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Measles (rubeola) | ☐ | ☐ | Cold Sores (Herpes simplex) | ☐ | ☐ |
| German Measles (rubella) | ☐ | ☐ | Canker sores (apthous ulcers) | ☐ | ☐ |
| Chicken Pox (varicella) | ☐ | ☐ | Mumps | ☐ | ☐ |
| Hepatitis (infectious) (HEP-A) | ☐ | ☐ | Infectious Mononucleosis | ☐ | ☐ |
| (serum) (HEP-B) | ☐ | ☐ | Thrush (monilial infection) | ☐ | ☐ |

Has your child ever been hospitalized? ☐ YES ☐ NO If so, when/where? _____

For what reason? _____

Has your child ever had a blood transfusion or been given blood products ☐YES ☐ NO

For what reason? _____

Have you or your child been tested POSTIVE for the HIV virus? ☐ YES ☐NO Who/When? _____

Is your child under the care of a cardiologist? ☐YES ☐NO Name: _____

Has the cardiologist or your family doctor informed you of your child's need to be placed on prophylactic antibiotic therapy prior to his/her dental procedures? _____

Has your child had any history of:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| ALLERGIES | | | BLEEDING DISORDER | ☐ | ☐ |
| Food | ☐ | ☐ | RESPIRATORY DISORDER | ☐ | ☐ |
| Pollen | ☐ | ☐ | Asthma | ☐ | ☐ |
| Drug | ☐ | ☐ | Cystic Fibrosis | ☐ | ☐ |
| Other | ☐ | ☐ | Other | ☐ | ☐ |
| HEART DISEASE | | | GASTRO-INTESTINAL DISORDER | | |
| Rheumatic | ☐ | ☐ | Diabetes Melilitus | ☐ | ☐ |
| Congenital | ☐ | ☐ | Diabetes Insipidus | ☐ | ☐ |
| Other | ☐ | ☐ | Liver: Jaundice | ☐ | ☐ |
| GENITOURINARY DISORDER | | | Hepatitis | ☐ | ☐ |
| Bladder | ☐ | ☐ | Other | ☐ | ☐ |
| Kidney | ☐ | ☐ | SEIZURE DISORDERS | ☐ | ☐ |
| IMMUNOLOGICAL DISORDER | ☐ | ☐ | HISTORY OF ABUSE/NEGLECT | ☐ | ☐ |
| LEARNING DISORDER | ☐ | ☐ | SPEECH PROBLEMS | ☐ | ☐ |
| PHYSICAL DISORDER | ☐ | ☐ | CHEMOTHERAPY | ☐ | ☐ |
| EMOTIONAL DISORDER | ☐ | ☐ | RADIATION TREATMENT | ☐ | ☐ |
| TRAUMA OR ACCIDENT | ☐ | ☐ | | | |

Has your child had any unfavourable reactions to drugs? ☐NO ☐ YES

Is yoru child presently on medication? IF yes, describe/dosage: _____

IF YES TO ANY OF THE ABOVE, PLEASE DESCRIBE: _____

_____

_____

_____

_____

_____

_____

**Medical History Update** If change, record in service rendered:

| Date | Normal | Change | Signature | Date | Normal | Change | Signature |
|---|---|---|---|---|---|---|---|
| _____ | ☐ | ☐ | _____ | _____ | ☐ | ☐ | _____ |
| _____ | ☐ | ☐ | _____ | _____ | ☐ | ☐ | _____ |
| _____ | ☐ | ☐ | _____ | _____ | ☐ | ☐ | _____ |

CONSENT TO TREATMENT

It is necessary that a signed permission be obtained from a parent or guardian before any and/or all necessary dental services can be started, because yoru child is a minor. Authorization is hereby granted as such. If during the course of such treatment, in Hertiage Dental Centre's opinion and judgement, any treatment or procedure different from that now contemplated should be indicated in respect of which there is no reasonable opportunity for additional explanation and authorization, you further request and authorize them to do whatever they consider advisable. Furthermore, the individual indicated on this form will be responsible for any account incurred on this child for dental treatment and understand that the account is due at each appointment, or whatever arrangement has been previously mutually agreed upon with Heritage Dental Centre.

Name of Parent / Guardian (Please Print) _____ Relationship: _____

Signature of Parent / Guardian: _____ Date: _____

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