CHILD REGISTRATION - MEDICAL HISTORY

PATIENT INFORMATION

Child's Family Name_____ First Name_____
Date of Birth_____ Medicare no. _____ Expiry date_____
Address_____ City_____ Prov._____
Postal Code_____ Tel. _____ E-mail_____
School_____ Grade_____ Favourite Hobby _____
How did you hear about our office? _____

PARENTS

Name	Work No.	Cell
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Legal Guardian(s) (if other than parents)_____
- Person(s) financially responsible for child _____
- Is child covered by a dental insurance plan? _____yes _____no

DENTAL HISTORY

- Is this a first dental visit? __yes __no, date of last dental visit _____
- Is child complaining of any dental problems? _____
- Has child had any unhappy dental experiences? _____
- Please circle if applicable

Any injuries to: mouth - teeth - head
Mouth habits: thumb sucking - nail biting - mouth breathing – pacifier - grinding - nursing bottle - other_____

- Any unusual speech habits? ___no ___yes, specify_____
- Any lost teeth due to injury? _____no _____yes
- Does your child see an Orthodontist?___no___yes

If yes, name of Orthodontist_____

- Does child brush teeth daily? ___no ___yes, how many times a day_____
- Is dental floss used? ___no ___yes, how often_____
- Do you assist child with brushing/flossing? ___yes ___no
- Is fluoride taken in any form? _____
- Child's attitude to dentistry / oral hygiene _____positive _____negative

OVER →

HEALTH HISTORY

Child's Physician _____Telephone no. _____
Date of last physical examination_____Results_____

- Is child under care of a physician for a medical problem? ___ yes ___ no

If yes, specify_____

- Is child presently taking any medication? ___ yes ___ no

If yes, specify_____

- Has child ever been hospitalized? ___ yes ___ no

If yes, specify_____

- Has child ever had surgery? ___ yes ___ no

If yes, specify_____

- Is there excessive bleeding when cut? ___ yes ___ no
- Any allergies to penicillin or other antibiotics ___yes ___no

If yes, specify_____

- Any allergies to other medication ___ yes ___ no

If yes, specify_____

- Any other allergies (food – latex - pollen – animals – dust) ___ yes ___ no

If yes, specify_____

- Does child have good physical coordination? ___ yes ___ no
- Are there any emotional problems? ___ yes ___ no

If yes, specify_____

Has child had any of the following? (please circle):

Anemia	Chronic Sinus	Hearing Problems	Mastoid	Mononucleosis
Asthma	Convulsions	Heart Problems	Measles	Thyroid
Bladder Problems	Diabetes	Kidney Problems	Mumps	Tuberculosis
Cerebral Palsy	Epilepsy	Liver Problems	Rheumatic Fever	
Chicken Pox	Fainting	Malignancies	Other_____	

Summary (for doctor's use):

_____
_____
_____
_____

Consent for Treatment

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I assume responsibility for all fees associated with those procedures.

Parent's signature_____ Date_____