

CHILD REGISTRATION and HISTORY

PATIENT INFORMATION

Child's Family Name _____ First Name _____
Date of Birth _____ Medicare No. _____ Expiry date _____
Address _____ City _____ Prov. _____
Postal Code _____ Tel No. _____ E-mail _____
School _____ Grade _____ Favourite Hobby _____
How did you hear about our office? _____

RESPONSIBLE PARTY

Father's Name _____ Work Tel. No. _____ Cell. No. _____
Mother's Name _____ Work Tel No. _____ Cell. No. _____
Address and Tel. No. (if different from Child) _____ mom _____ dad

Legal Guardian (if other than parents) _____
Person Financially Responsible for child _____
Do you have dental insurance? Yes ___ No ___

DENTAL HISTORY

Is this a first dental visit? ___ yes ___ no, date of last visit to a dentist _____
Is child complaining of any dental problems _____
Any unhappy dental experiences _____

Please circle if applicable

- Any injuries to: mouth - teeth - head
- Any mouth habits: thumb sucking - nail biting - mouth breathing - pacifier nursing bottle - other _____

Any unusual speech habits _____ Any lost teeth due to injury _____

Does your child see an Orthodontist? ___no ___yes, Orthodontist's name _____

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 any 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 (latex - food - pollen - animals - dust)? ___ yes ___ no

If yes, specify _____

Does child have good physical coordination? ___ yes ___ no

If yes, specify _____

Are there any emotional problems? ___ yes ___ no

If yes, specify _____

Has child had:

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 will assume responsibility for fees associated with those procedures.

Parent's signature _____

Date _____