CHILDREN QUESTIONNAIRE 18 years of age or younger

Child's Name:_____ Birth Date: M:_____D:_____Yr:_____ Age: _____

School:_____Grade:_____ Sports/Hobbies: _____

Parent or Guardian's Personal Information

Name: ❑Mr. ❑ Mrs. ❑Miss. ❑ Ms. _____

Home Address:_____

City: _____ Province: _____Postal Code:_____ Email: _____

Tel: H: _____ W: _____ ext::_____ Cell: _____

Birth Date: M:_____D:_____Y._____ Age: _____ Birthplace: _____

Person responsible for this account:_____ Address (if different from above): _____

How did you hear about our office? _____

Have you seen us in the following: ❑T.V. Commercial ❑ Newspaper Ad. ❑ Magnet ❑ Fireworks Display ❑ Magazine Ad.
❑ Internet Web Site ❑ Sponsorship ❑ Yellow Pages ❑Other _____

Insurance Information

Do you have dental insurance?❑Yes❑ No Name of Insured: _____Birth Date: M:___D:___ Y: ___

Employer: _____ Address: _____ How Long ____ yrs.

Insurance Company Name: _____Check-up frequency: ❑twice/year❑6 months ❑ 9 months❑ 12 months

Policy or Group Number: _____ **I.D. or Certificate number:** _____

Dental and Medical History

Main dental concern regarding your child: ❑ broken teeth❑crooked teeth❑speech habits❑oral hygiene❑fluoride, Other:_____

Any mouth habits (eg.thumb sucking): _____

Last dental check-up: _____**month/year Is the child nervous about seeing a Dentist?:** ❑Yes ❑No

Name of last dentist:_____**Number of years as his/her patient:** _____

How old was the child when they had their first dental visit:_____age

Why have you changed dentists? _____

Has the child had any teeth extracted? ❑Yes ❑No **When?:** _____ years ago **Reason:** _____

DOES YOUR CHILD HAVE OR HAD ANY OF THE FOLLOWING? (please check if applicable)

❑ Teeth sensitive to: ❑Cold ❑Hot ❑Sweets ❑ Pressure
❑ Periodontal (gum) treatment
❑ Bleeding gums - if yes, how long? _____
❑ Frequent blisters on lips or mouth
❑ Orthodontic treatment
❑ Loose teeth
❑ Bad breath
❑ Food impaction
❑ Unpleasant taste
❑ Swelling in mouth

Family physician:_____ **Telephone:** _____ **Address:** _____

Is your child currently under medical treatment? _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING? (please check if applicable)

❑ Rheumatic Fever	❑ Heart Surgery	❑ Diabetes	❑ Communicable Diseases
❑ Heart Murmur	❑ Thyroid Disorder	❑ Tuberculosis	❑ Osteoporosis
❑ Congenital Heart Lesions	❑ Heart Attack	❑ Kidney Disease	❑ Surgery of any kind
❑ Infectious Endocarditis	❑ Stroke	❑ Asthma	❑ Hepatitis
❑ Prosthetic Surgery (Heart Valves, Hip Joint)	❑ Pacemaker	❑ Cancer	❑ Pregnancy
❑ HIV Positive/ Aids	❑ Anemia or Blood Problems	❑ High Blood Pressure	Due Date _____

❑ Allergies to Medication: (please check if applicable)

❑ Penicillin ❑ Sulpha ❑ ASA List Medications:_____
❑ Codeine ❑ Erythromycin ❑ Other:_____ Does your child smoke ❑ Yes ❑ No

Is there any other information about your child's health we should know? _____

I hereby consent to the performing of the dental and oral surgery procedures necessary or advisable for my child, including the use of local anaesthesia, nitrous oxide, x-rays and/or relevant analgesia as indicated and I accept responsibility for all fees charged for treatment rendered whether covered by insurance or not. In addition, I understand that a fee will be charged for missed appointments by my children where at least 48 hours notice is not provided. I also give consent to photos being taken and used for illustration of my child's treatment and to the submission of my dental claims electronically to my insurance company. I also consent to your collection, of any and all personal information about my child including personal health information whom I have joint or sole parental custody, and to use such information in any manner or for any purpose whatsoever, but only in the course, of, concerning, or relating to, your dental practice. I similarly consent to the disclosure to third parties of all such information but only in accordance with the Regulated Health Professions, the Dentistry, and Dental Hygiene Acts of Ontario, and to any insurer or other payment organization who may be responsible for payment of all or part of any treatment or service you provide.

Parent's Signature:_____**Date**_____