

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)

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

Family physician: _____ Telephone: _____ Address: _____

Is your child currently under medical treatment? _____

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

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

Allergies to Medication: (please check if applicable)

- | | | |
|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulpha | <input type="checkbox"/> ASA List Medications: _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Other: _____ Does your child smoke <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____