

**PATIENT INFORMATION
CHILDREN'S HISTORY**

Child's Full Name _____
Last First Middle

Address: _____
Street Apt City Prov. Postal Code

Home Tel: (_____) _____ Date of Birth: ____/____/____ Sex M F
day month year

Mother's Name: _____ Father's Name: _____
Last First Last First

Brother's & Sister's Names: _____

Whom may we thank for referring you? _____

Emergency contact: _____ Tel: (_____) _____ Relationship _____

Person responsible for account: Name: _____

Address (if different from above) _____ Tel: (_____) _____

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise it will be necessary to charge for the time lost. Office policy is that services are paid for at each visit as they are performed.

Confidential Medical History

Family Physician: _____ Tel: (_____) _____

Is your child ALLERGIC to anything? Yes No If yes, describe _____

When did your child last visit the physician? _____ Reason _____

Has your child ever had any serious illness or been in the hospital? _____

If so, describe _____

Does your child or any other family member have a LATEX sensitivity? Yes No
Does your child or any other family member have a LATEX ALLERGY? Yes No

Does your child have a heart murmur? Yes No

Has your child ever had any of the following?

- | | | | | |
|--|--|--|---|---------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Asthma | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Operations |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gland Trouble | <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Physical Deformity | <input type="checkbox"/> Chest Pains | |

Does your child suffer from any health concerns / conditions we should be aware of? _____

Does he or she bruise easily or bleed profusely for a long period of time? _____

Does your child have any blood disease? _____

Does your child have any emotional problems? _____

Is your child now taking, or have they had:

Penicillin _____ Other Antibiotics _____

Local Anaesthesia _____ General Anaesthesia _____ Other Drugs _____

Have they had any unfavorable reaction to these drugs? _____

Is there a history of any inherited diseases in the family? _____

If Yes, describe _____

DENTAL HISTORY

Has your child had previous dental care? _____ When? _____

Previous Dentist: _____

Have they had an unpleasant experience associated with dental treatment? Yes No

If yes, describe _____

Has your child ever had an accident, injury or surgery relating to the mouth? _____

Is there a family history of: (tick, if yes)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> High decay rate | <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Cleft lip/or palate | <input type="checkbox"/> Tooth deformity |
| <input type="checkbox"/> Extra teeth | <input type="checkbox"/> Gum disease | <input type="checkbox"/> Spaced teeth | <input type="checkbox"/> Crooked teeth |

Does your child have any oral habits such as: (tick, if yes)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Nail biting | <input type="checkbox"/> Chewing (eg. pencils) | <input type="checkbox"/> Finger sucking |
| <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Tongue thrusting | <input type="checkbox"/> Lip biting | <input type="checkbox"/> Teeth grinding |

Has your child ever had orthodontic treatment? Yes No

How often does your child brush their teeth? _____ Do you supervise the child while tooth brushing? _____

Has your child ever received fluoride supplements in the diet or water supply? _____

ADDITIONAL INFORMATION

If there is any specific problem regarding your child's oral health which concerns you, or if there is any additional information which you feel may be helpful in our care of your child, please state below

Ontario has a Privacy Protection Legislation that the Cataraqui Dental Centre strictly adheres to. (For more information please ask to see the Cataraqui Dental Privacy Policy) I agree that the Cataraqui Dental Centre can collect use and disclose personal information in accordance with Ontario's Privacy Laws.

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 and I will assume responsibility for fees associated with those procedures.

Parent's Signature _____ Date _____

WE WELCOME NEW PATIENTS

www.cataraquidental.com
