CHILDREN'S MEDICAL 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

E mail address: ____

Brother's & Sister's Names:____

How did you hear about our office? radio television friend / family other ________________________________

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 2 business days 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: (________) ______________________

Health Card Number: (OHIP Number) ____

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 ____

Is your child presently taking any medication?____

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?

Measles	Asthma	Shortness of Breath	Kidney Disease	Operations
Mumps	Hay Fever	Lung disease	Diabetes	Epilepsy
Chicken Pox	Heart Trouble	Tuberculosis	Gland Trouble	Tonsils
Scarlet Fever	Rheumatic Fever	Nervous Disorder	Broken Bones	Strep Throat
Fainting Spells	Liver Disease	Physical Deformity	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)

High decay rate	Missing teeth	Cleft lip/or palate	Tooth deformity
Extra teeth	Gum disease	Spaced teeth	Crooked teeth

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

Thumb sucking	Nail biting	Chewing (eg. pencils)	Finger sucking
Mouth breathing	Tongue thrusting	Lip biting	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
Email: info@cataraquidental.com