CHILD QUESTIONNAIRE

In order to render optimum health service, it is necessary to become acquainted with the vital information related to each patient. Of course all the information is strictly confidential. Although some questions may seem unimportant at the moment, they may be vital in case of an emergency. Therefore, please answer every question.

Please feel free to ask the receptionist for help in completing this form.

I. PERSONAL HISTORY (Please Print)

Today's Date: ______________________________

Child's Full Name: ____

Nickname: _____________________ Age: _______ Birthdate: _____________________

Home Address: ____

Postal Code: __________________ Phone #: ____

School: ____________________________________ Grade: ______________________________

Father's Name: _____________________ Occupation: _________________________________

Employed By: _______________________ Business Phone #: ___________________________

Mother's Name: ____________________ Occupation: ________________________________

Employed By: _______________________ Business Phone #: ___________________________

Child's Physician: ____________________ Phone #: __________________________________

Do you have dental insurance? _________ Policy Number: _____________________________

Certificate Number: ______________ Name of person insured: _____________________

II. MEDICAL HISTORY

		YES	NO
1.	Is this child now under care of a physician? ________________	☐	☐
	If so, explain: ____		
2.	Has this child ever had any serious illness or been treated in the hospital? ____________ ____	☐	☐
	If so, explain: ____		
3.	Is this child now taking any medications? __________________	☐	☐
	What kind? ____		
4.	Is this child allergic to any medication or food? ______________	☐	☐
	List: ____		
5.	Has this child ever had any unfavourable reaction to any previous medical or dental care? ____	☐	☐

6. Has this child ever had any of the following?

Measles	□	Ear Aches	□	Fainting Spells	□
Mumps	□	Hay Fever	□	Chicken Pox	□
Asthma	□	Shortness of Breath	□	Multiple Sclerosis	□
Pains in Chest	□	Scarlet Fever	□	Heart Trouble	□
Strep Throat	□	Muscular Dystrophy	□	Rheumatic Fever	□
Tonsillitis	□	Lung Disease	□	Bruise Easily	□
Blood Disease	□	Prolonged Bleeding	□	Diabetes	□
Epilepsy	□	Kidney Disease	□	Liver Disease	□
Tuberculosis	□	Nervous Disorder	□	Psychiatric Care	□

Other Major Disease □: ____

III. DENTAL HISTORY

		YES	NO
1.	Has this child had previous dental care? ____________________	□	□
	If so, how long ago? ____		
2.	Has this child ever had an accident, injury or surgery involving the mouth? ____________________	□	□
3.	Has this child ever had an unpleasant experience associated with a dental visit? ____________________	□	□
	If yes, describe ____		
4.	Is this child particularly nervous about visiting the dentist?	□	□
5.	Has this child's teeth ever been treated with decay-preventing Fluoride? ____________________	□	□
6.	Has this child ever had orthodontic treatment? _____________	□	□

7. Does this child have/have had any oral habits such as:

Thumb Sucking	□	Finger Sucking	□	Nail Biting	□
Tongue Thrusting	□	Mouth Breathing	□	Lip Biting	□
Teeth Grinding	□	Other: ____________________			

8. Is there family history of:

High Decay Rate	□	Crooked Teeth	□	Gum Disease	□
Missing Teeth	□	Malformed Teeth	□	Extra Teeth	□

9. How often does this child brush his or her teeth? ____________________________
10. Any Additional Information: ____

IV. PARENT'S CONSENT FOR CHILDREN UNDER 18

I hereby consent to the performing of the Dental and Oral Surgery procedures necessary or advisable for my children, including the use of local anaesthesia and/or relative analgesia as indicated, and I accept responsibility for the fee.

Date: _______________________ Parent's Signature: __________________________