GET ACQUAINTED QUESTIONNAIRE

To render optimum health services it is necessary to become acquainted with each patients vital information. This information will remain confidential. PLEASE ANSWER EVERY QUESTION. Some information may seem unimportant at the moment but may become vital in case of an emergency. Feel free to ask the receptionist for help in completing this form. PLEASE PRINT.

PERSONAL HISTORY

Date _____

Child s Full Name _____

Home Address _____

Postal Code _____ Phone (_____) _____

Cell (_____) _____ Email _____

Age _____ Birthdate D _____ M _____ Y _____ Nickname _____

Grade _____ School _____

Name and Ages of Siblings _____

Father s Name _____ Occupation _____

Employed By _____ Bus. Tel.(_____) _____

Mother s Name _____ Occupation _____

Employed By _____ Bus. Tel.(_____) _____

Child s Physician _____ Tel.(_____) _____

Do you have dental insurance? _____

Policy Number _____ % Covered _____

Name of person responsible for account _____

MEDICAL HISTORY

	YES	NO
1. Is the child currently under the care of a physician?	☐	☐
If so, explain _____		
2. Has the child ever had a serious illness or been in the hospital?	☐	☐
If so, explain _____		
3. Is the child currently taking any medication?	☐	☐
If so, explain _____		
4. Is the child allergic to any medicine or food?	☐	☐
If so, list _____		
5. Has the child ever had any unfavourable reaction to previous medical or dental care?	☐	☐
If so, explain _____		

6. Has the child ever had any of the following conditions? (Please check ✓)

☐ Ankle swelling	☐ Hay Fever	☐ Nervous disorder
☐ Asthma	☐ Heart trouble	☐ Prolonged bleeding
☐ Blood disease	☐ Jaundice	☐ Psychiatric care
☐ Bruise easily	☐ Kidney trouble	☐ Rheumatic Fever
☐ Chest pains	☐ Liver disease	☐ Scarlet Fever
☐ Chicken Pox	☐ Lung disease	☐ Shortness of breath
☐ Diabetes	☐ Measles	☐ Strep Throat
☐ Ear aches	☐ Multiple Sclerosis	☐ Tonsillitis
☐ Epilepsy	☐ Mumps	☐ Tuberculosis
☐ Fainting spells	☐ Muscular Dystrophy	☐ Other _____

DENTAL HISTORY

	YES	NO
1. Has the child had previous dental care?	☐	☐
If so, how long ago _____		
2. Has the child ever had an accident, injury or surgery about the mouth?	☐	☐
If so, describe _____		
3. Has the child ever had an unpleasant experience associated with a dental visit?	☐	☐
If so, describe _____		
4. Is the child particularly nervous about visiting the dentist?	☐	☐
5. Have the child s teeth been treated with decay preventing Floride?	☐	☐
6. Has the child ever had Orthodontic treatment?	☐	☐

7. Does the child have any oral habits such as

☐ Finger sucking	☐ Teeth grinding
☐ Lip biting	☐ Tongue thrusting
☐ Mouth breathing	☐ Thumb sucking
☐ Nail biting	☐ Other _____

8. Is there a family history of:

☐ Crooked teeth	☐ High decay rate
☐ Extra teeth	☐ Malformed teeth
☐ Gum disease	☐ Missing teeth

9. How often does your child brush their teeth? ☐ ☐

10. Additional information _____

_____

PARENTS 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. I also accept responsibility for the fee.

Date _____ Parent s Signature _____

OFFICE POLICY

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. However, in certain circumstances arrangements for payment may be made by consulting the doctor.