**MEDICAL AND DENTAL QUESTIONNAIRE FOR CHILDREN**  
The following information is required to thoroughly diagnose and give you personal attention. Please fill out the form completely.

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| **PERSONAL INFORMATION**  Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last First Middle DD/MM/YYYY Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PostalCode\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (HM)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(WK)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employed By\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Martial Status\_\_\_\_\_\_ In case of emergency, Notify: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation\_\_\_\_\_\_\_\_\_\_\_ Personal Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dental Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Po.#(cert.and/or group)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIN of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where Insured works\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to insured: **□Son □ Daughter □Spouse □ Other** | | | | | |
| **PRESENT STATE OF HEALTH**  1. Do you consider yourself in good health?...................................................................................................................... 2. Are you presently under observation or treatment for any complaint (medical or dental? ……………………………………..  3. Are you taking ANY drugs or medications, either prescribed or self? ………………………………………………………………………  If yes, please circle: Tranquilizers; aspirins; diuretics; sleeping pills; heart pills; birth control; steroids;  Others: 4. Have you noticed any excess fatigue from normal work?.............................................................................................  5. Have you had any changes in your appetite? ...............................................................................................................  6. Are you on any special diet? ......................................................................................................................................... 7. Has your weight been constant? .................................................................................................................................. 8. At room temperature, do you normally feel either cold or very warm? ..................................................................... 9. Have you noticed any on the following? (Please circle)…………………………………………………………………………………………….  ankles swelling; sleeping poorly; needing more than one pillow to sleep; going to the washroom often.  at night; bruising easily; bleeding for a long time  10. Do you have ANY allergies? Hay fever, asthma, others? ............................................................................................ 11. Do you have ANY sensitivity or allergies to any drugs? ..............................................................................................  12. (FOR WOMEN ONLY) Are you pregnant? What month? ............................................................................................. | **□ YES □ YES □ YES   □ YES □ YES □ YES □ YES □ YES □ YES   □ YES □ YES □ YES** | □ **NO □ NO**  **□ NO   □ NO □ NO □ NO □ NO □ NO □ NO   □ NO □ NO □ NO** | | | |
| **MEDICAL HISTORY**  1. When did your child last visit the physician?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Has your child ever had any serious illness or been in the hospital?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Does your child have any known medical, physical, or mental handicaps?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Has your Child ever had any of the following?   |  |  |  |  | | --- | --- | --- | --- | | □ Measles  □ Mumps □ Chicken Pox □ Scarlet Fever □ Strep. Throat □ Tonsils □ Adenoids □ Ear troubles | □ Hay fever  □ Heart Trouble  □ Rheumatic Fever □ Chest Pains □ Fainting Spells  □ Ankle Swelling  □ Abnormal Blood Pressure  □ Liver Disease | □ Shortness of Breath □ Blood Transfusion □ Kidney Disease □ Lung Disease  □ Tuberculosis  □ Nerve Disorder □ Epilepsy □ Asthma | □ Jaundice  □ Diabetes  □ Gland Trouble  □ Broken Bones  □ Operations  □ Physical Deformity  □ OTHER | | | | |  |  |
| **DENTAL HEALTH** 1. Has your child had previous dental care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Has he or she ever had an unpleasant experience associated with dental treatment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If yes, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Has your child ever had an accident, injury or surgery about the mouth?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Does your child have any oral habits such as (tick if yes)   |  |  |  |  | | --- | --- | --- | --- | | □ Thumbsucking  □ Mouth Breathing | □ Nail Biting  □ Tongue Thrusting | □ Chewing( e.g. Pencils)  □ Lip Biting | □ Fingersucking  □ Teeth Grinding | | | |  | |  |

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| **ADDITIONAL INFORMATION**  **If there is any specific problem regarding your child’s oral health which concerns you, or there is any additional information which you feel may be helpful in our care of your child, please state below.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **YOUR ACCOUNT**  □ If you do not have dental insurance, then payment is due as services are rendered.  □ If you have dental insurance, and are regular patients at our office, we allow a courtesy period to receive reimbursement from your insurance company.   Remember that your dental plan is a contract between your insurance company and you, not your dentist. Like any contact, beware of the *fine print.* For example, many plans claim 100% coverage but may have a deductible, or may not cover all procedures, or may use an outdated Ontario Dental Association Fee Schedule. You are responsible for their uninsured portions. Please bring your booklets and questions to our staff who will be glad to assist you.  □There will be a $ 100.00 charge per patient if patient does not show up for confirmed appointment.  **PERMIT FOR OPERATIONS**  This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures as agreed to between myself and the dentist, and will assume responsibility for fees (or if I have insurance, the uninsured portions of the fees) associated with those procedures.  **Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |