CHILDREN'S HEALTH QUESTIONNAIRE

The following information is required to thoroughly diagnose and treat any condition and for us to give you the highest possible standard of professional services. All information will be kept strictly confidential. Please ask us for assistance if you do not understand something on this questionnaire.

GENERAL INFORMATION

Name ______________________ Usually Called ______________

Address ______________________ Telephone ______________

City ______________ Province ______________ Postal Code ______________

Father's Name ______________________ Occupation ______________

Employed by ______________ Telephone ______________ Cell ______________

Mother's Name ______________________ Occupation ______________

Employed by ______________ Telephone ______________ Cell ______________

Family Physician or Pediatrician ______________________

Name of Person Responsible for this Account ______________________

AHC # ______________________

Referred by ______________________

CHILD'S HISTORY

Age ______________ Date of Birth ______________

Brother's and Sister's Name ______________________

Are you seeking treatment for any particular reason and /or routine dental care? ______________________

____

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? ______________________
   Is so, describe ______________________
3. Has your child ever had any of the following?

☐ Measles	☐ Asthma	☐ Shortness of Breath	☐ Kidney Disease
☐ Mumps	☐ Hay Fever	☐ Lung Disease	☐ Diabetes
☐ Chicken Pox	☐ Heart Trouble	☐ Tuberculosis	☐ Broken Bones
☐ Strep Throat	☐ Chest Pains	☐ Epilepsy	☐ Operations
☐ Tonsils	☐ Fainting Spells	☐ Liver Disease	☐ Physical Deformity
☐ Adenoids	☐ Ankle Swelling	☐ Hepatitis A B (circle)	☐ Ear Trouble
☐ Speech/or/Language Disorder	☐ Abnormal Blood Pressure	☐ Jaundice	☐ Other

   If yes to any of the above, describe ______________________
4. Is your child allergic to anything? ______________________
   If yes, describe ______________________
5. Does he or she bruise easily or bleed profusely for a long period of time? ______________________
6. Does your child have any blood disease? ______________________
7. Does your child have any emotional problems? ______________________
8. Is your child now taking, or has he or she had:
   Penicillin Other Antibiotics Cortisone
   Local Anesthesia General Anaesthesia Other Drugs
   Has he or she had any unfavorable reaction to these drugs? ______________________

   ____

PLEASE SEE REVERSE SIDE

DENTAL HISTORY

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 involving the mouth? ______________
4. Has your child ever had orthodontic treatment? ______________
5. How often does your child brush his or her teeth? ______________
6. Do you supervise the child while toothbrushing? ______________
7. Has your child ever received oral hygiene or toothbrushing instruction from a dentist or a dental hygienist? ______________
8. It is the policy of this office to emphasize preventive dentistry. Do you agree with this approach? ☐ Yes ☐ No

ADDITIONAL INFORMATION

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

____

____

____

Date ______________________ Signed ______________________

Father/Mother/Guardian

OFFICE POLICY

We require immediate payment for services rendered.

CONSENT

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advicable (including the use of general or local aneathetics as indicated). I will assume responsibility for all fees associated with all procedures.

Patient's Signature ______________________ Date ______________