Child & Teen

GET ACQUAINTED 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 information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency. Therefore PLEASE ANSWER EVERY QUESTION.

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

Personal History (Please Print)

Date ____________________

Name ____________________ Home Address ____________________

Nickname ____________________ Postal District ____________________

Age _____ Birthdate ____________________ Phone ____________________

Birthplace ____________________ Names and Ages of Brothers and Sisters ________

School ____________________ ____________________

Grade ____________________ ____________________

Father's Name ____________________ Mother's Names ____________________

Occupation ____________________ Occupation ____________________

Employed By ____________________ Employed By ____________________

Bus. Phone ____________________ Bus. Phone ____________________

Do you have dental insurance? __________

Policy Number ____________________ Child's Physician ____________________

% Covered ____________________ Phone ____________________

Name of person responsible for account ____________________

Medical History

YES	NO	
❑	❑	Is child now under the care of a physician? If so, explain ____________________
❑	❑	Has child ever had any serious illness or been treated in the hospital? If so, explain ____________________
❑	❑	Is child now taking any medication? What? ____________________
❑	❑	Is the child allergic to any medicine or food? List ____________________
❑	❑	Has child ever had any unfavorable reaction to any previous medical or dental care? ____________________
❑	❑	Has child ever had any of the following conditions?

- ❑ Measles
- ❑ Mumps
- ❑ Chicken Pox
- ❑ Scarlet Fever
- ❑ Strep Throat
- ❑ Tonsillitis
- ❑ Ear Aches
- ❑ Hay fever
- ❑ Asthma
- ❑ Muscular Dystrophy
- ❑ Shortness of breath
- ❑ Lung Disease
- ❑ Fainting Spells
- ❑ Ankle Swelling
- ❑ Pains in chest
- ❑ Heart Trouble
- ❑ Rheumatic fever
- ❑ Bruise easily
- ❑ Prolonged bleeding
- ❑ Multiple Sclerosis
- ❑ Blood disease
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Jaundice
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Tuberculosis
- ❑ Nervous disorder
- ❑ Psychiatric Care
- ❑ HIV Positive
- ❑ Other major disease ____________________

Dental History

YES	NO	
❑	❑	Has child had previous dental care? If so, how long ago? ________
❑	❑	Has child ever had an accident, injury or surgery about the mouth? If yes, describe ________
❑	❑	Has child ever had an unpleasant experience associated with a dental visit? If yes, describe ________
❑	❑	Is your child particularly nervous about visiting the dentist?
❑	❑	Have child's teeth ever been treated with decay-preventing Fluoride?
❑	❑	Has child ever had Orthodontic treatment?
❑	❑	Does child have any oral habits such as:

- ❑ Thumb Sucking
- ❑ Nail Biting
- ❑ Finger Sucking
- ❑ Mouth Breathing
- ❑ Lip Biting
- ❑ Teeth Grinding
- ❑ Tongue Thrusting
- ❑ Other ________

❑ ❑ Is there any family history of:

- ❑ High Decay Rate
- ❑ Extra Teeth
- ❑ Gum Disease
- ❑ Missing Teeth
- ❑ Malformed Teeth
- ❑ Crooked Teeth

How often does your child brush his or her teeth? ________
Additional Information ________

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 ________

Office Policy

Your appointment 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. (i.e. 2 working days.) 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 or office manager.

Please indicate one of the following with a check mark:

- ❑ I have dental insurance with ________.
- ❑ I wish to pay each visit as the services are performed.
- ❑ I wish to know the total fee for all the work to be done, as well as the number of appointments necessary, so that I can pay equal portions at each appointment.
- ❑ I wish to discuss special arrangements for payment with the doctor.