GET ACQUAINTED QUESTIONNAIRE – CHILD

The information requested is very important. Please make it as complete and accurate as you can because it will help us to provide the best possible health service. This information form becomes part of our permanent records and will be held in the **strictest confidence.**

Personal Information

Patient's Name: ____ Gender: _____ Date of Birth: M ___ D ___ Y ___ Age: ________

Prefers to be called: _______________________________ Name of Parents or Guardian: ____

Address: ____ Phone: (____) ______ - ______

City: ____ Province: ________________________________ Postal Code: ___________

Name of School: ____ Grade: ________

Are there other family members presently at our office? ☐ Yes ☐ No If yes, please list names: __________________________________

____

Do you have any pets, hobbies or special interests? ☐ Yes ☐ No If yes, please list kind of pet and name: ________________________

____

Whom may we thank for referring you to us? ____

Is there any other information you believe would be helpful to us? ☐ Yes ☐ No If yes, please comment: ________________________

____

____

Insurance Information

Primary Insurance:

Name of Insured: ____________________________ Date of Birth: M ___ D ___ Y ___ Employer: ____________________________

Insurance Company: __________________________ Policy Number: ________________ Certification Number: _________________

Check Up Frequency: ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (explain) ____

Secondary Insurance:

Name of Insured: ____________________________ Date of Birth: M ___ D ___ Y ___ Employer: ____________________________

Insurance Company: __________________________ Policy Number: ________________ Certification Number: _________________

Check Up Frequency: ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (explain) ____

Dental History

Please check the reason(s) for seeking dental care:

Routine checkup	☐	Appearance of teeth	☐	Accident to teeth	☐
New examination	☐	Swelling of face	☐	Bleeding around mouth	☐
Toothache	☐	Crowding of teeth	☐	Other	☐

Has there been a previous dentist? ☐ Yes ☐ No If yes, was it: Your family dentist ☐ A specialist ☐

Has there been a previous facial or dental injury? ☐ Yes ☐ No What was the cause of the accident? _________________________

____

At what age? ________________________________ Which teeth were involved? ____

If there are any of the following habits, please check:

Lip sucking/biting ☐ Thumb or finger sucking ☐ Nail biting ☐

Has there been any unfavorable experience in a dental or medical office? ☐ Yes ☐ No If yes, please explain: ____________________

____

Medical History

Is your child presently under observation or treatment for any condition? ? □ Yes □ No If yes, please explain: ___________________

____

Is your child currently taking any medications, whether prescribed or non-prescribed? This includes aspirin, cold remedies and antibiotics? Please specify: ____

Does your child have, or has your child ever had, any medical disorder, including (specify):

Heart Problems	□	Seizure disorders	□
Rheumatic fever	□	Emotional/mental disorders	□
Heart surgery	□	Congenital defects	□
Hemophilia	□	Diabetes	□
Sickle cell anemia	□	Hepatitis or other liver disorders	□
Thalassemia	□	Fifths disease	□
Chicken Pox	□	Strept Throat	□
Allergies	□	Any condition not listed above:____	

Specify: ____

Does your child bruise easily or bleed profusely for a long period of time? □ Yes □ No

Has your child ever had surgery of x-ray treatment for any tumor, growth or other condition? ? □ Yes □ No If yes, please explain:

____

Has your child been hospitalized for any reason? Specify: ____

Has your child had a general or local anaesthetic? ? □ Yes □ No

Family Physician: ____ Phone: (____) ______ - ______

NOTES: ____

____

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GENERAL RELEASE (Please sign after completing medical questionnaire.)

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history for my child and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my child's medical – dental history. **Should there be any change in my child's health status in the future, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures upon my child as may be required to determine necessary treatment. I understand that information provided from or to my child's medical doctor or another health care provider may be necessary. I understand that responsibility for payment of the dental services for my dependents is mine, and I assume responsibility for fees associated with these services.

X ____ ______________________________________

(Signature) Parent □ Guardian □ (print name of guardian)

Reviewed by Treating Dentist: ____________________________________ Date: ____________________________