Orchard Heights DENTAL CENTRE

Family, Cosmetic and Implant Dentistry

St. Andrews Shopping Centre
2 Orchard Heights Blvd. Unit 45
Aurora Ontario L4G 3W3

Tel: (905) 727-8586 | Fax: (905) 727-4283 | Email: info@orchardheightsdental.ca

Patient Information - Child

Your cooperation in filling out the data on the confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain in this office.

Childs : First name : Last name : Middle name :

Date of Birth (dd/mm/yyyy) : Sex : ☐ Male ☐ Female

Address : Street : Town :

Province : Postal Code :

Contact Info : Home Phone : Work Phone :

Cell Phone : **Email Address :**

In Case of Emergency, please notify :

Name : Relationship :

Address : Telephone :

Whom may we thank for referring you?

Insurance Information

Name of person responsible for account :

Address : Street : Town :

Province : Postal Code :

Dental Ins. : ☐ Yes ☐ No Name of Company :

Ins. Policy # : Employee I.D. #

Dental Insurance Subscriber - Name : Date of Birth (dd/mm/yyy) :

☐ Yes ☐ No I authorize release to my insurance company plan administrator the information contained in claims submitted electronically.

Name of Parent / Guardian

Childs History

Nickname :

Name and ages of any brothers and sisters :

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

Other Comments :

Confidential Medical History

1. When did your child last visit the physician :

Reason :

2. Name of family physician: - Phone :

3. Has your child ever had any serious illness or been in hospital? If so, why?

☐ Yes ☐ No - Reason :

4. Does your child have any medical, physical or mental disorders?

☐ Yes ☐ No - Details :

5. Has your child ever had any of the following? (please check)

☐ Asthma	☐ Diabetes	☐ Kidney Disease	☐ Operations
☐ Lung Disease	☐ Liver Disease	☐ Heart Trouble	☐ Jaundice
☐ Scarlet Fever	☐ Abnormal Blood Pressure	☐ Broken Bones	☐ Shortness of Breath
☐ Epilepsy	☐ Chest Pains	☐ Fainting Spells	☐ Tuberculosis
☐ Adenoids	☐ Physical Deformity	☐ Ear Trouble	☐ Nervous Disorder
☐ Rheumatic Fever	☐ Other		

If yes to any of the above, please describe :

6. Is your child allergic to anything ?

☐ Yes ☐ No - Details :

7. Does he/she bruise easily or bleed profusely for a long period of time?

☐ Yes ☐ No - Details :

8. Does your child have any blood diseases?

☐ Yes ☐ No - Details :

9. Does your child have any emotional problems?

☐ Yes ☐ No - Details :

Confidential Medical History - Continued

10. Is your child now taking or has he/she ever had :

☐ Penicillin ☐ General Anesthesia ☐ Local Anesthesia ☐ Cortisone ☐ Other Antibiotics ☐ Other Drugs

11. Has he/she had any unfavourable reaction to these drugs?

12. Any inherited family diseases?

13. Heart disease, murmur, congenital heart defects? ☐ Yes ☐ No

14. Please list any other conditions that your child has:

Confidential Dental Information

Has your child had previous dental care? ☐ Yes ☐ No When :

Has he/she ever had an unpleasant experience associated with dental treatment? ☐ Yes ☐ No

Describe :

Has your child ever had an accident, injury or surgery to the mouth?

☐ Yes ☐ No Describe :

Is there a family history of : (please check)

☐ High Decay Rate ☐ Extra Teeth ☐ Spaced Teeth ☐ Cleft Lip or Palate

☐ Tooth Deformity ☐ Missing Teeth ☐ Crooked Teeth ☐ Gum Disease

If Yes, describe :

Does your child have any oral habits such as : (please check)

☐ Thumb Sucking ☐ Lip Biting ☐ Mouth Breathing ☐ Nail Biting

☐ Finger Sucking ☐ Chewing(e.g. pencils) ☐ Teeth Grinding ☐ Tongue Thrusting

If Yes, describe :

Has your child ever had orthodontic treatment? :

How often does your child brush his/her teeth? :

Has your child ever received oral hygiene or tooth brushing instruction from a dentist or dental hygenist? :

Has your child ever received fluoride supplements in the diet or water supply? : ☐ Yes ☐ No

Were his/her teeth ever treated with decay-preventing topical fluorides? : ☐ Yes ☐ No

Additional Information

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

CONSENT FOR TREATMENT

This certifies that I the undersigned, consents to the agreed upon, necessary, or advisable dental procedures.I will assume full responsibility for the fees associated with these procedures.

Signature : Date :