Tot2Teen DENTAL

"Your Child's Care is Our Focus!"

**Patient's Name:**_____ DOB: _____

## Health and Dental History

1. Is your child in good health? _____
2. Your child's physician's name and telephone number:

_____

3. Has your child ever had a health problem? _____
4. Has your child ever been hospitalized? - reason(s), date(s)

_____

5. Is your child allergic to anything? - please list both foods and medications/supplements

_____

6. Is your child taking any medications? - list medications, dose and reasons

_____

7. Were there any problems at birth? _____
8. Does your child have any of the following conditions:

| | | |
|---|---|---|
| □ **Heart disease** | □ **Anemia** | □ **Skin disease (eczema)** |
| □ **Heart murmur** | □ **Rheumatic fever** | □ **Visual, hearing, sinus problems** |
| □ **Anemia** | □ **Blood transfusion** | □ **Malignant hyperthermia** |
| □ **Hemophilia** | □ **Stomach ulcers** | □ **Fainting spells** |
| □ **Liver disease** | □ **Kidney disease** | □ **Infectious disease** |
| □ **Seizures** | □ **Cerebral palsy** | □ **Speech or hearing problems** |
| □ **Recurrent headaches** | □ **Diabetes** | □ **Congenital birth defects** |
| □ **Eyesight problems** | □ **AIDS/HIV** | □ **Asthma/breathing problems** |
| □ **Cancer/tumors** | □ **Cleft lip/palate** | □ **Endocrine/growth problems** |
| □ **Social problems** | □ **Autism** | □ **Other** _____ |

Please explain:_____

9. Was your child breast or bottle fed? At what age did it stop? _____
10. Does your child snore nightly? Any signs or diagnosis of sleep apnea?

_____

11. Has your child ever been to a dentist? - list the name of the dentist and date

_____

12. Has your child experienced any unfavourable reaction(s) from dental care? - explain

_____

13. Is your child having any problems with .....

| | | |
|---|---|---|
| □ **Cavities** | □ **Trauma/accident** | □ **Crowding/orthodontics** |
| □ **Toothache/pain** | □ **Gum infections** | □ **Jaw sounds** |
| □ **Sensitive teeth** | □ **Discoloured teeth/stains** | □ **Other** _____ |

14.Does your child have any exposure to fluoride? - toothpaste, supplements, mouth rinse or varnish from a public health unit? _____

I, the undersigned, verify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my physician being contacted if necessary to obtain information that is required for my child's dental care. I authorize the dentist to perform the diagnostic procedures that may be required to determine the necessary treatment and assume financial responsibility for dental services rendered for my child.

Parent/Guardian signature: _____ Date: _____

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