MARKHAM HERITAGE HEALTH CLINIC – DENTISTRY CHILD

Name_____ Sex: M / F Marital Status:_____
Address: _____ City: _____ Postal Code_____
Home Tel# _____ Bus# _____ __Cell# _____
E-mail address: _____ May we call you at work? _____
Date of Birth_____ Employer _____ Occupation _____
In case of emergency, whom may we contact? _____ Phone: _____
How did you hear about our office? /Who can we thank for referral: _____

Medical Questionnaire **Circle One**

Are you presently under the care of a physician? When was last physical Yes No
If so, specify_____
Are you taking any medicines (antibiotics, birth control, painkillers etc) Yes No
If yes, please list all medications that you take, the doses and what they are for

_____ _____
_____ _____
_____ _____

Have you ever been hospitalized? If so, when and how long? _____ Yes No
Do you have drug allergies? If so, specify _____ Yes No
Have you ever had an unusual reaction to any drugs or medications? Yes No
If so, specify _____
Do you have any other allergies (food, latex, metal, hay fever)? Yes No
If so, specify _____
Do you have a bleeding problem or disorder? If so, specify _____ Yes No
Have you had radiation treatment or chemotherapy? If so, explain _____ Yes No
If so, explain _____

Do you have or have you ever had any of the following? (Please circle all that apply)

Anemia	Cancer	Heart Trouble	Rheumatic fever
Arthritis	Diabetes	Hepatitis A,B,C/ Jaundice	Stomach/ intestinal trouble
Artificial Heart Valve	Eating Disorders	Herpes type I/ type II	Strokes
Artificial joint/implants	Epilepsy/ seizures	High/ Low blood pressure	Thyroid disease
Asthma	Head/ Neck injuries	HIV virus/ AIDS	Tuberculosis
Blood disorders	Heart Murmur	Kidney disease	Other:

Do you wish to speak to the dentist privately about any matter? Yes No

Dental Information

Does your child have any dental problems? Yes No
If so, specify_____
Has your child been to the dentist before? Yes No
If so, specify_____
Has your child ever had a serious/ difficult problem associated with dental work? Yes No
If so, specify_____
Does your child have a finger or thumb habit? Yes No
Has your child ever had an injury to the face or jaw? Yes No
Are you happy with the appearance of your child's teeth? Yes No
How often does your child brush? _____
How often does your child floss? _____
Does your child snore? Yes No
Does your child drink juice or pop regularly? Yes No How much a day? _____

Insurance Information

Name of Insured: _____Birth Date of Insured: _____
Insurance Company: _____ Group # _____ID# _____
Do you have any additional insurance? Yes No If yes, complete the following:
Name of Insured: _____Birth Date of Insured: _____
Insurance Company: _____ Group # _____ID# _____

Who is responsible for this account? _____

Financial Policy*:*

The parent or guardian assumes responsibilities of all fees associated with treatment and fully understand that payment is expected on the date of treatment.

Consent for Treatment: This is to certify that the parent or guardian, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary if advisable, including the use of local anesthetic as indicated and accept the Financial Policy above.

Signature:_____ Date: _____

Reviewed by treating dentist: _____ Date: _____