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 receptionist for help in completing this form.

I. PERSONAL HISTORY (Please Print)

Date ____________________

Childs Full Name ____________________

Home Address ____________________

Postal Code ____________________ Phone ____________________

Age ________ Birthdate ____________________ Birthplace ____________________

School ____________________ Grade ____________________

Nickname ____________________

Names and Ages of Brothers and Sisters ____________________

____

Fathers Name ____________________ Occupation ____________________

Employed By ____________________ Bus. Phone ____________________

Mothers Name ____________________ Occupation ____________________

Employed By ____________________ Bus. Phone ____________________

Childs Physician ____________________ Phone ____________________

Do you have dental insurance? ____________________

Policy Number ____________________ % Covered ____________________

Name of person responsible for acount ____________________

II. MEDICAL HISTORY

	Yes	No
1. Is child now under the care of a physician? ________	☐	☐
If so, explain ________		
2. Has child ever had any serious illness or been treated in the hospital? ________	☐	☐
If so, explain ________		
3. Is child now taking any medicine? ________	☐	☐
What? ________		
4. Is child allergic to any medicine or food? ________	☐	☐
List ________		
5. Has child ever had any unfavourable reaction to any previous medical or dental care? ________	☐	☐

6. Has child ever had any of the following conditions?

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

III. DENTAL HISTORY

	Yes	No
1. Has child had previous dental care? ______	☐	☐
If so, how long ago? ______		
2. Has child ever had an accident, injury or surgery about the mouth? ______	☐	☐
If yes, describe ______		
3. Has child ever had an unpleasant experience associated with a dental visit? ______	☐	☐
If yes, describe ______		
Is the child particularly nervous about visiting the dentist? ______	☐	☐
4. Have child's teeth ever been treated with decay-preventing Fluoride? ______	☐	☐
5. Has child ever had Orthodontic treatment? ______	☐	☐

6. Does child have any oral habits such as:

- Thumb Sucking ______ ☐
- Finger Sucking ______ ☐
- Lip Biting ______ ☐
- Tongue Thrusting ______ ☐
- Nail Biting ______ ☐
- Mouth Breathing ______ ☐
- Teeth Grinding ______ ☐
- Other ______ ☐

7. Is there a family history of:

- High Decay Rate ______ ☐
- Gum Disease ______ ☐
- Malformed Teeth ______ ☐
- Extra Teeth ______ ☐
- Missing Teeth ______ ☐
- Crooked Teeth ______ ☐

8. How often does your child brush his or her teeth? ______

9. Additional Information ______

IV. 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 ______

V. OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 24 hours notice, otherwise it will be necessary to charge for the time lost.

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.

Please indicate one of the following with a check mark:

1. ☐ I have dental insurance.
2. ☐ I wish to pay each visit as the services are performed.
3. ☐ 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.