

# SOUTHPOINTE DENTAL

## CHILD PATIENT QUESTIONNAIRE

Today's Date \_\_\_\_\_

Child's Name		Usually Called	
Date of Birth	Telephone Number	E-mail Address	
Address			
City		Province	Postal Code
Male/Female		School	
Height		Weight	
Fathers Name		Address (if different than above)	
Home Phone	Work Phone	Employed By	Occupation
Mothers Name		Address (if different than above)	
Home Phone	Work Phone	Employed By	Occupation
Nearest Relative not living with you			
Address			
City		Province	Postal Code
Phone Number		Relationship	
Child's Former Dentist	Credit Card # (if extending credit)		Exp. Date

## INSURANCE

Primary Insurance Company		Employee Name		Employer
SIN #		Date of Birth		
Group/Policy #		ID #	% covered	
Secondary Insurance Company		Employee Name		Employer
SIN #		Date of Birth		
Group/Policy #		ID #	% covered	
Name of person responsible for this account				

WHOM MAY WE THANK FOR REFERRING YOU?

## OFFICE POLICY

Our office policy is that services are paid for in full at each visit as they are performed. If you are unable to keep your appointment, we will require 24 hours notice, otherwise it may be necessary to charge for time lost. We have the right to charge interest on accounts over 60 days in arrears (1.5% month/19.6% per annum).

### ALL CHARGES INCURRED WITH RESPECT TO YOUR ACCOUNT ARE YOUR FULL RESPONSIBILITY

The undersigned hereby authorizes Southpointe Dental the authority to obtain or deliver information through credit reporting agencies if financial arrangements are required or delinquent accounts are existing. I also acknowledge that all dental fees incurred are my responsibility.

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_ Relationship \_\_\_\_\_

## CHILD MEDICAL INFORMATION

Is your child experiencing pain or discomfort? \_\_\_\_\_ When was their last dental visit? \_\_\_\_\_

Please describe any unpleasant experiences associated with dental treatment \_\_\_\_\_

Has your child ever had an accident, injury or surgery about the mouth? \_\_\_\_\_

Is there any family history of dental problems? \_\_\_\_\_ Please specify \_\_\_\_\_

Does your child have any oral habits? (eg. thumbsucking, mouth breathing) \_\_\_\_\_

Has your child ever had orthodontic treatment? \_\_\_\_\_

How often does your child brush his or her teeth? \_\_\_\_\_

Is your child receiving daily fluoride at the present time? \_\_\_\_\_

Is your child in good health? \_\_\_\_\_ Has there been a change in their general health within the past year? \_\_\_\_\_

Is your child under the care of a physician? \_\_\_\_\_ If so, what condition is being treated? \_\_\_\_\_

Physician's Name \_\_\_\_\_ City \_\_\_\_\_ Phone # \_\_\_\_\_

Has your child been hospitalized or had a serious operation or illness within the last 5 years? \_\_\_\_\_

Does your child have any of the following diseases or problems? Please circle any that apply:

Heart Murmur	Congenital Heart Condition	AIDS or HIV related disorder
Rheumatic Fever	Liver Disease	Hepatitis
Tuberculosis (TB)	Asthma	Hay Fever
Allergies or Hives	Anemia	Kidney Trouble
Bruise easily	Diabetes	Pain in Jaw Joints
Fainting or Dizzy Spells	Epilepsy or Seizures	Cold Sores
Blood Transfusion	Nervousness	

Is your child taking any drug or medicine? \_\_\_\_\_ If yes, what drugs or medicines \_\_\_\_\_

Is your child allergic or reacted adversely to any drugs or medicines? \_\_\_\_\_ If yes, what drugs or medicines? \_\_\_\_\_

Please circle any others which apply:

Aspirin	Erythromycin	Novocain/Xylocain	Scopioamine
Codeine	Local Anesthetic	Penicillin	Sleeping Pills
Darvon	Nembutal/Seconal	Percodan	Tetracycline
Demerol	Nitrous Oxide	Other Antibiotics	

Has your child had any serious trouble associated with any previous dental treatment? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

Has your child had abnormal bleeding associated with previous extractions, surgery or trauma? \_\_\_\_\_

Is there any history of family disease? \_\_\_\_\_

Does your child have a disease, condition or problem not listed above that you think I should know? \_\_\_\_\_

## TREATMENT AND MEDICAL CONSENT

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anaesthetic as indicated.

I acknowledge the above information to be accurate and true to the best of my knowledge.

Parent or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_ Relationship \_\_\_\_\_