404 DENTAL

HEALTH QUESTIONNAIRE

A. PERSONAL DATA

Today's Date _____

Patients Name: _____ (Last / First / All / Nickname)

Date of Birth: _____ Sex: _____

Address: _____

_____ Home Phone No. _____

Mothers Name: _____ (Last / First) Business Phone No. _____

Fathers Name: _____ (Last / First) Business Phone No. _____

Mothers Email: _____ Cell Phone No. _____

Fathers Email: _____ Cell Phone No. _____

Parents Are: Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐

Child Lives With: Mother ☐ Father ☐ Both ☐

Person Responsible for Payment: Mother ☐ Father ☐ Both ☐ Other ☐ _____ (Specify)

Dental Insurance Company Name: _____ (Group No.)

Pediatrician or Family Doctor: _____

Who reffered you to us? _____

B. PRESENT STATE OF HEALTH- (Please Answer for your Child)

1. Has there been any change in your general health in the past year? (if yes, describe).

_____ YES NO

2. Are you under the care of a physician or have you seen one in the past year? (if yes, describe).

_____ YES NO

3. Are you taking any medication at the present time? (if yes, describe).

_____ YES NO

4. Are you allergic to anything? (if yes, describe).

_____ YES NO

5. Do you bruise easily or have you prolonged bleeding after an extraction, operation, or cut? (if yes, describe).

_____ YES NO

6. Have you experienced fainting, shortness of breath or chest pains?(if yes, describe).

_____ YES NO

C. PAST MEDICAL HISTORY

1. Has your child ever been treated for: (Please Circle)

1. Heart Disease
2. Stroke
3. Rheumatic fever
4. Scarlet Fever
5. Heart Murmur
6. Abnormal Blood Pressure
7. Ulcers
8. Epilepsy
9. Tuberculosis
10. Jaundice
11. Hepatitis
12. Liver Disease
13. Kidney Disease
14. Diabetes
15. Arthritis
16. Glaucoma
17. Cancer
18. Anaemia
19. Blood Disorders
20. Mental/ Nervous Disorders
21. STI
22. Injury to Face or Jaws
23. Asthma
24. Hay Fever
25. Aids
26. Skin Rashes
27. Developmental Delay
28. Slow Learner

2. Has your child ever had a serious illness or been hospitalized? (if yes, describe).

_____ YES NO

3. Has your child ever had a reaction to a local or general anaesthetic? (if yes, describe).

_____ YES NO

4. Is there anything the dentist should know regarding your child's dental or medical history that has not been mentioned? (if yes, describe).

_____ YES NO

D. OFFICE POLICY

1. Office policy is that services are paid for at each visit as they are performed. Your insurance coverage is a contract between you and the carrier and may not fully reimburse you for services rendered.

2. I hereby consent to the performing of Dental services necessary for my child, and I accept responsibility for the Fee.

Date. _____ Parent Signature. _____