LAIRD EGLINTON DENTAL

Pedodontic-Child

Medical/Dental History Form

Name: _____
Last Init First

Address: _____
Street (apt#) City Postal Code

Home: ( ) _____ Cell: ( ) _____ Work: ( ) _____

Date of Birth: D D / M M / Y Y Y Y Email: _____

Person Responsible for Childs account: _____ Health Card #: _____

Emergency Contact: _____ Phone: ( ) _____

Does your Child have dental insurance? Y N If Yes complete the following….

Primary Insurance

Company: _____ Policy Holder: _____

Policy/Plan/Group: _____ Certificate/I.D.:_____

Policy holders Date of Birth: : D D / M M / Y Y Y Y Relation to Holder: _____

Secondary Insurance

Company: _____ Policy Holder: _____

Policy/Plan/Group: _____ Certificate/I.D.:_____

Policy holders Date of Birth: : D D / M M / Y Y Y Y Relation to Holder: _____

Health History

Has there been any change in your childs general health? ..... Y N

If YES please describe: _____

Is your child being treated for any medical condition or have they been treated within the past 2 years? ..... Y N

If YES please describe: _____

Is your child currently being treated by a physician for a specific condition? ..... Y N

If YES please describe: _____

Is your child currently taking any medication? ..... Y N

Name of Medication/Condition	Dose

Does your child have any allergies? ..... Y N

If yes, please list: _____

Does your child bleed or bruise easily? ..... Y N

Has your child ever been hospitalized? ..... Y N

If YES please describe: _____

Has your child ever received general anesthesia? ..... Y N

Continued on next page…….

Has your child ever had an adverse reaction to local anesthetic? ..... Y N
Does your child have any allergies to medications? ..... Y N
If YES please list: _____
Does your child have any other allergies? ..... Y N
If YES please list: _____
Does your child currently have any of the following conditions? (Please circle)

Heart Murmur	Rheumatic Fever	Jaundice	Radiation Therapy	Stroke
AIDS/HIV	Hepatitis A/B	Thyroid Disease	Mental Illness	Diabetes
Heart Condition	Cancer	Steroid Therapy	Epilepsy	Kidney Disease
Asthma	Liver Disease			

Is there anything else the doctor needs to know regarding your childs medical health? ..... Y N

If YES please explain: _____

Dental History

Has your child ever been to the dentist before? If yes, what age? _____ ..... Y N

Is your child currently experiencing any pain or discomfort? ..... Y N

Are any of your teeth sensitive to: ___ Cold? ___ Hot? ___Sweet? ___Biting?

If Yes, which teeth or areas? _____

Does your child have difficulty chewing food or does food get stuck between their teeth? ..... Y N

Has your child ever had an injury to your jaw or face? ..... Y N

Has your child been examined by an ORTHODONTIST regarding growth patterns and development? ..... Y N

PATIENT CERTIFICATION AND CONSENT

I the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I will assume full responsibility for the fees associated with these procedures. I agree to the privacy policies posted in the reception area and consent to the electronic sharing of information with my insurance company for the purpose of processing insurance claims and determination of benefits. Unless other arrangements have been made assignment of benefits from your insurance company will be set up. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and my dentist. I authorize the dentist to treat me and I assume full responsibility for all fees. I am aware that 2 business days notice is required to change or cancel an appointment without charge.

_____ _____
SIGNATURE (PARENT OR GUARDIAN IF UNDER 16) DATE

_____ _____
DENTIST'S SIGNATURE DATE