

PAEDO CHART - CHILDREN UNDER 12 YEARS OLD

NAME _____ AGE _____ BIRTH DATE _____

HOME ADDRESS _____ PHONE _____

PARENT'S OCCUPATION _____ BUS. PHONE _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

DENTAL INSURANCE (Please Circle) YES NO

NAME OF INSURANCE CARRIER _____

POLICY NUMBER _____ GRP # _____ SERVICES COVERED _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Medical-Dental History

Why did you bring your child for a dental visit? _____

	Yes	No
Do you (parent) fear dental treatment for yourself?	<input type="checkbox"/>	<input type="checkbox"/>
Is this your child's first dental visit?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have any health problem?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child taking any medication now?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child experienced an unfavourable or allergic reaction to penicillin, aspirin, local anaesthetic or any other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child had any of the following:		
heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
asthma	<input type="checkbox"/>	<input type="checkbox"/>
breathing difficulties	<input type="checkbox"/>	<input type="checkbox"/>
rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
allergies	<input type="checkbox"/>	<input type="checkbox"/>
epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>
bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
anaemia	<input type="checkbox"/>	<input type="checkbox"/>
kidney or liver involvement	<input type="checkbox"/>	<input type="checkbox"/>
throat or tonsil problems	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had any injury, accident or surgery about the mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had an unpleasant dental visit?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>

Parent Consent

I consent to the performing of any dental and oral surgical procedures necessary or advisable for my child _____ including the use of local anaesthesia, x-rays and drugs and I assume responsibility for fees associated with those procedures.

Date _____ Signature _____