WELCOME TO DR. STACEY'S HAPPY TOOTH HOUSE !!!

PATIENT INFORMATION

Child's Name _____ □ Male □ Female Age_____
Last Name First Name Middle Initial

Address _____
Street Address City Province Postal Code

Home Phone# _____ Other #'s (specify)_____

Birthdate_____ School _____ Grade_____
Day/ Month/ Year

Person responsible for account_____ Relationship to child_____

Notify in case of emergency_____
Name Relationship Phone #

Whom may we thank for referring you? _____ Hobbies/ Sports_____

DENTAL HISTORY

What would you like us to do for your child today?_____
Date of last dental care/xrays_____ Former Dentist_____
How often does your child brush?_____ Floss?_____
Does your child experience pain or discomfort in the jaw joint? _____ □ Yes □ No
Has your child ever experienced a mouth or chin injury?_____ □ Yes □ No
Does your child have speech problems? _____ □ Yes □ No
Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? _____ □ Yes □ No
Child's habits affecting the mouth or teeth: □ Thumb sucking □ Nail biting □ Other_____
Other information about your child's dental health or previous treatment _____
_____

MEDICAL HISTORY

Child's Physician _____ Phone#_____ Date of last visit_____
Has your child had any serious illness or operations?_____
Has your child ever had a blood transfusion? □ Yes □ No If yes, dates_____
Check if your child has any of the following:

□ AIDS/ HIV Positive	□ Diabetes	□ Hemophilia/Abnormal bleeding	□ Sinus problems
□ Anemia	□ Epilepsy		□ Skin Rash
□ Artificial joints/limbs	□ Fainting	□ Immunizations current	□ Spina Bifida
□ Asthma	□ Food Allergies:	□ Kidney disease	□ Thyroid disease
□ Austism	_____	□ Latex allergy	□ Tonsillitis
□ Blood disease	□ Headaches	□ Liver disease	□ Tuberculosis
□ Cancer	□ Hearing Impairment	□ Mitralvalve prolapse	□ Other: _____
□ Chicken Pox	□ Heart Murmur	□ Respiratory disease	_____
□ Convulsions	□ Heart Problems:	□ Rheumatic/Scarlet fever	_____
□ Cough, persistent	_____	□ Shortness of breath	_____

DENTAL INSURANCE

Primary Insurance-Member Name _____ D.O.B._____
Insurance Company_____ Policy/Group#_____ ID#_____
Secondary Insurance-Member Name _____ D.O.B._____
Insurance Company_____ Policy/Group#_____ ID#_____

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change to my child's medical status I will inform the dentist. I understand that payment is due in full at the time services are rendered.

Parent/Guardian Signature x_____ Date_____
Name of Parent/Guardian_____