Willow Dental Associates
2021 Cliff Road, Suite 310, Mississauga, Ontario L5A 3N7
Tel: (905) 279-5050 Fax: (905) 279-5170 www.willowdental.com

CHILD'S FULL NAME: _____ **ACCOUNT NO.:** _____

DATE OF BIRTH: _____ **DATE:** _____

In order to render optimum health service, it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment, they may be vital in case of emergency. Therefore **PLEASE ANSWER EVERY QUESTION.**

Please feel free to ask clinician for help in completing this form.

I. MEDICAL HISTORY

	YES	NO	?
1. Is child now under the care of a physician?	❑	❑	❑
If so, explain _____			
2. Has child ever had any serious illness or been treated in the hospital?	❑	❑	❑
If so, explain _____			
3. Is child now taking any prescription, non-prescription or herbal medicine regularly?	❑	❑	❑
What? _____			
4. Is child allergic to any medicine or food?	❑	❑	❑
List _____			
_____			
5. Has child ever had any unfavourable reaction to any previous medical or dental care?	❑	❑	❑
If so, explain _____			

Has child ever had any of the following conditions?

- ❑ Heart murmur/mitral valve prolapse
- ❑ Joint replacement (hip, knee, etc.)
- ❑ Measles
- ❑ Mumps
- ❑ Chicken Pox
- ❑ Scarlet Fever
- ❑ Strep Throat
- ❑ Tonsillitis
- ❑ Ear Aches
- ❑ Hay Fever
- ❑ Asthma
- ❑ Muscular Dystrophy
- ❑ Malignant Hyperthermia
- ❑ Shortness of breath
- ❑ Lung Disease
- ❑ Fainting spells
- ❑ Ankle Swelling
- ❑ Pains in chest
- ❑ Heart trouble
- ❑ Rheumatic fever
- ❑ Bruise easily
- ❑ Prolongued bleeding
- ❑ Multiple Sclerosis
- ❑ Hepatitis B
- ❑ AIDS or exposure to HIV virus
- ❑ Blood disease
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Jaundice
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Tuberculosis
- ❑ Nervous disorder
- ❑ Psychiatric care
- ❑ Other major disease

_____

_____

_____

II. DENTAL HISTORY

		YES	NO	?
1.	Has child had previous dental care?	❑	❑	❑
	If so, how long ago? _____			
2.	Has child ever had an accident, injury or surgery about the mouth?	❑	❑	❑
	If yes, describe _____			
3.	Has child ever had an unpleasant experience associated with a dental visit?	❑	❑	❑
	If yes, describe _____			
4.	Has child particularly nervous about visiting the dentist?	❑	❑	❑
5.	Have child's teeth ever been treated with decay preventing Fluoride?	❑	❑	❑
6.	Has child ever had Orthodontic treatment?	❑	❑	❑

7. Is there a family hystory of:

❑ High Decay Rate _____ ❑ Extra Teeth _____

❑ Gum Disease _____ ❑ Missing Teeth _____

❑ Malformed Teeth _____ ❑ Crooked Teeth _____

Additional Information _____

_____

_____

III. DIETARY HISTORY

1. How much and how often does child eat/drink the following:

❑ Milk _____ ❑ Cookies _____

❑ Soft Drinks _____ ❑ Dried Fruits _____

❑ Candy _____ ❑ Cake _____

❑ Gum _____ ❑ Sweet Desserts _____

		YES	NO	?
2.	Does child take lunches to school?	❑	❑	❑
	Content: _____			
3.	Does child eat three meals a day?	❑	❑	❑
4.	Does child snack frequently?	❑	❑	❑
	Content: _____			
5.	How often does your child brush his/her teeth? _____			
	Floss _____	❑	❑	❑
	Toothpaste _____			

IV. PARENT'S CONSENT FOR CHILDREN UNDER 18

I hereby consent to the performing of the Dental and Oral Surgery procedures necessary or advisable for my children, including the use of Local Anaesthesia and/or Relative Analgesia as indicated, and I accept responsibilty for the fee.

Date _____ Parent's Signature _____