WILLOW DENTAL
FAMILY, AESTHETIC & IMPLANT DENTISTRY

CHILDREN'S MEDICAL & DENTAL HISTORY

DATE: _____

CHILD'S FULL NAME: _____ DATE OF BIRTH: _____

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

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 _____			

	YES	NO	?
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 history of?

□ Cavities	□ 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 Drink	_____	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 _____

INFORMED CONSENT/GENERAL RELEASE

I, THE UNDERSIGNED STATE THAT I HAVE PROVIDED AN ACCURATE AND COMPLETE MEDICAL/DENTAL HISTORY AND HAVE NOT KNOWINGLY OMITTED ANY INFORMATION. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND RECEIVE ANSWERS REGARDING THIS MEDICAL/DENTAL HISTORY AND I CONSENT TO MY PHYSICIAN BEING CONTACTED IF NECESSARY. I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC, DENTAL AND ORAL SURGERY PROCEDURES AND SERVICES INCLUDING THE USE OF ANESTHETIC AS BE NECESSARY. I CONSENT TO PHOTOGRAPHS TAKEN DURING MY APPOINTMENT OR WHILE IN THE OFFICE AND UNDERSTAND THAY THEY MAY BE USED FOR DIAGNOSTIC, TEACHING/LEARNING AND/OR MARKETING PURPOSES.

Our Commitment

At Willow Dental Associate, we are committed to excellence. We feel that you deserve nothing less when it comes to your health. We use the best materials and techniques available in order to provide you with quality you have come to expect from us.

We believe that our relationship with you, as with all relationships, needs open and clear communication. We will try to communicate all your dental needs and estimate your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning your dental health.

We understand how valuable your time is, so we make every effort to remain on time. We do not double book our appointments. We feel that you deserve our complete and focused attention so that we may provide the best care possible. Your reserved time is exclusively yours.

Your Commitment

We want you to be comfortable with our team. If you ever have any questions about your dental treatment, financial or insurance questions, or any concerns at all, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise.

Your portion of your dental treatment is expected at the time of your services. For your convenience we do accept many forms of payment including cash, cheque, Visa and MasterCard. In addition, we also offer third party financing, which includes both interest free programs and extended financing.

Your scheduled appointment is reserved exclusively for you. We have a 2-business day cancellation policy in order to provide you with this personalized attention. We understand that circumstances may arise that require an appointment to be rescheduled. We are happy to change your appointment time if 2 business days' notice are given. If sufficient notice is not given, your account will automatically be charged a $100 missed appointment fee. We ask that you make every effort to keep your reserved time.

PATIENT (PATIENT, GUARDIAN) SIGNATURE: _____

IF PARENT, GUARDIAN, PLEASE PRINT NAME: _____

DATE: _____

DOCTOR SIGNATURE: _____