Get Acquainted Questionnaire

For child or adult under guardianship

Date: _____
yy/mm/dd

Child's Full Name: _____ Date of Birth: _____
yy/mm/dd

Nickname (if any): _____ Sex ❑ M ❑ F

Home Address: _____

Postal Code: _____ Telephone: _____

Family email address: _____

School: _____ Grade: _____

Father's Name: _____ Occupation: _____

Employed by: _____ Business Phone: (_____) _____

Mother's Name: _____ Occupation: _____

Employed by: _____ Business Phone: (_____) _____

Names and ages of brothers/sisters: _____

_____

Person responsible for this account: _____

Address (if different from above): _____

Employer: _____ Telephone: (_____) _____

In case of emergency, please call: _____ Telephone: (_____)_____

Do you have dental insurance? _____ Insurance Company Name _____

Policy/Group number: _____ Certificate/ID number: _____

Medical History

	Yes	No
Is child now under the care of a physician? _____	❑	❑
If so, please explain: _____		
Has child ever had a serious illness or been treated in the hospital? _____	❑	❑
If so, please explain: _____		
Is child currently taking any medication? _____	❑	❑
If so, please specify: _____		
Is child allergic to any medication, food(s) or latex? _____	❑	❑
If so, please list here: _____		
Has child had any unfavourable reaction to any previous medical or dental care? _____	❑	❑

Has the child had any of the following conditions?

Measles	❑	Shortness of Breath	❑	Blood disease	❑
Mumps	❑	Lung disease	❑	Diabetes	❑
Chicken Pox	❑	Fainting Spells	❑	Epilepsy	❑
Scarlet Fever	❑	Strep Throat	❑	Kidney disease	❑
Tonsillitis	❑	Heart trouble	❑	Liver disease	❑
Ear aches	❑	Rheumatic fever	❑	Tuberculosis	❑
Hay Fever	❑	Bruising easily	❑	Nervous disorder	❑
Asthma	❑	Prolonged bleeding	❑	Muscular Dystrophy	❑

Other major illness: _____

Is there anything else about your child that we should be aware of? _____

_____

Dental History

	Yes	No
Has child had previous dental care? _____	❑	❑
If so, how long ago? _____		
Has child ever had an accident, injury or surgery about the mouth? _____	❑	❑
If so, please describe: _____		
Does your child wear recommended mouth or head protection for sports? _____	❑	❑
Has child ever had an unpleasant experience associated with dental care? _____	❑	❑
If so, please describe: _____		
Is child particularly nervous about visiting the dentist? _____	❑	❑
Has child's teeth ever been treated with decay-preventing Fluoride? _____	❑	❑

Does child have any oral habits such as:

Thumb sucking	❑	Nail biting	❑	Finger sucking	❑
Mouth breathing	❑	Lip biting	❑	Teeth grinding	❑
Tongue thrusting	❑	Other, please specify:	❑	_____	

How often does your child brush his or her teeth? _____ Floss? _____

Additional comments? _____

_____

Parent's/Guardian's Consent for Children Under 18

I, the undersigned, have provided an accurate and complete medical history of my child. I have also taken the opportunity to ask any questions and receive answers regarding the above. Since a change of medical condition or medication can affect dental treatment, I agree to notify this dental office of any changes at a subsequent appointment.

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

Date: _____ *Signature:* _____

Please Note

Your appointment time is especially reserved for you. If you cannot keep the appointment, we require 24 hours notice. If we are not notified you will be charged for that lost time. Office policy is such that services are paid for at each visit as they are performed. However, in special circumstances, arrangements for payment can be made by consulting with the Doctor.