

Infant/Toddler New Patient Questionnaire and Medical History

Welcome to My Dental Home. We are glad you are here.

Should you have any questions please feel free contact us at contact@mydentalhome.com or (647) 493-1885

Name: _____ PREFERRED NAME _____

Address: _____

City: _____ Prov.: _____ Postal Code _____

HOME PHONE _____ Legal Guardian: Phone _____ Cell: _____

Legal Guardian Email: _____

MM/DD/YY

DATE OF BIRTH _____ Parent Driver's Licence _____

Person Responsible For Account: _____

Employed By: _____

Who Can We Thank For Referring You To Our Office: _____

In Case Of An Emergency Please Contact:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Dental Benefits Information

Policy Holder: _____ DATE OF BIRTH:: _____

EMPLOYER NAME: _____ SIN: _____

INSURANCE CARRIER _____

POLICY/GROUP #: _____ CERTIFICATE #: _____

☐ Yes / No

Policy Holder: _____ DATE OF BIRTH:: _____

EMPLOYER NAME: _____ SIN: _____

INSURANCE CARRIER _____

POLICY/GROUP #: _____ CERTIFICATE #: _____

I AUTHORIZE RELEASE TO MY INSURANCE COMPANY/PLAN ADMINISTRATOR, THE INFORMATION CONTAINED IN CLAIMS SUBMITTED ELECTRONICALLY.

Signed

Date

HEALTH HISTORY

Please read and answer Y or N to each of the following as they apply to your child:

- ☐ Allergies (seasonal)
- ☐ Excessive Bleeding
- ☐ Nervousness/Depression
- ☐ Anemia
- ☐ Fainting
- ☐ Pacemaker
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Respiratory Problems
- ☐ Artificial Heart Valve
- ☐ Heart Conditions
- ☐ Radiation (head/neck)
- ☐ Artificial Joints
- ☐ Heart Lesions
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Heart Murmur
- ☐ Rheumatism
- ☐ Blood Disease
- ☐ Heart Surgery
- ☐ Scarlet Fever
- ☐ Bruise Easily
- ☐ Hepatitis A B C
- ☐ Seizures
- ☐ Cancer
- ☐ High/Low Blood Pressure
- ☐ Sinus Problems
- ☐ Chemotherapy
- ☐ HIV Positive
- ☐ Stomach Problems
- ☐ Diabetes
- ☐ Jaw Joint Pain
- ☐ Stroke
- ☐ Dizziness
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Drug Addiction
- ☐ Liver Disease/Jaundice
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Mitral Valve Prolapse
- ☐ Ulcers

Does your child have any of the following allergies:

- ☐ Aspirin
- ☐ Sulfa
- ☐ Penicillin
- ☐ Latex
- ☐ Codeine
- ☐ Other:
- ☐ Metal/jewelry
- ☐ Erythromycin
-

Have you ever been instructed to give your child antibiotics prior to dental care?

Is your child under a physician's care:

Routine Care:

Specific Conditions:

Is your child taking any medications:

I allow my child's medical doctor to be consulted if necessary.

Physician's Name: Phone:

Questionnaire:

1: Tell me how you care for your infant/child's Teeth:

2: Does your child use a bottle? Yes / No If NO please go to Question 3

Name all the products you fill the bottle with:

How often a day does your infant/child have with the bottle?

Is the bottle given: At night: Duration: (minutes) or all night: (hours)

Day: as per schedule Yes / No or "at will"

3: Is your child breast fed? How often a day does your infant/child breast feed:

At night: Duration: (minutes) or all night: (hours)

Day: as per schedule Yes / No or "at will"

4: Does your child use a sippy cup?

How often a day does your child have a sippy cup? Or is the sippy cup used "at will": Yes / No

5: List the most common snacks consumed by your infant/child:

6: Does the infant/child's parent(s), siblings or caregivers have decay or unresolved dental issues? Yes / No

7: Is there fluoride in your tap water? Yes / No

8: Please circle any habits:

Pacifier

thumb sucking

finger biting

Grinding/clenching

mouth breathing

Other: _____

9: Are you aware of snoring and/or difficulty breathing during sleep? **Yes / No**

10: Are you aware of any injuries to the teeth or gums? **Yes / No**

11: What concerns you the most about your infant/child's dental health? _____

The above personal and medical history for my child is complete and accurate, and I have not knowingly withheld information. I authorize the dentist to perform diagnostic procedures and administer treatment. I will be presented with options and allowed to ask questions. I understand that responsibility for payment for all procedures during treatment is mine.

Signature

Date

Dr. Initials