WELCOME TO PEACHTREE KIDS DENTAL
General Dental Health Questionnaire

The data on this confidential questionnaire is essential in performing the highest standard of pediatric dental care for you child. We would appreciate your co-operation in carefully filling out this form so that we will have accurate records on your child.

Today's Date: _____

Child's Information:

Name: _____ Birthday: _____ *(Day/Month/Year)*

Nickname: _____ Sex: _____ Age: _____ Grade: _____

Names and ages of siblings (*optional):*_____

Who is responsible for making dental appointments: _____

Parent / Legal Guardian Information:

Name: _____ Relationship to Child: _____

Date of Birth: _____ *(Day/Month/Year)*

Address: _____
Street City Province Postal Code

Name: _____ Relationship to Child: _____

Date of Birth: _____ *(Day/Month/Year)*

Address: _____
Street City Province Postal Code

Who does child currently reside with: _____

Contact Information:

Phone number(s) / email we may routinely use to contact you:

Home Phone: _____

Mom's Cell Phone: _____ Work Phone: _____

Dad's Cell Phone: _____ Work Phone: _____

Email Address: _____

***How did you hear about our office? (*Please specify*) _____**

Flip Over

Medical History

When did you child last visit the physician? _____

Reason: _____

Are your child's immunizations up to date? Yes ☐ No ☐

_____

Has your child ever had an serious illnesses or been in the hospital? Yes ☐ No ☐

If so, describe: _____

Does your child have any known medical, physical, or mental handicaps? Yes ☐ No ☐

If so, describe: _____

Did the mother have any problems during pregnancy or delivery? Yes ☐ No ☐

If so, describe: _____

Has your child ever had any of the following? *If yes, please check the appropriate boxes and enter date.*

☐ Heart Issues _____	☐ Mumps _____	☐ Hay Fever _____	☐ Jaundice _____
☐ Hepatitis _____	☐ Liver Disease _____	☐ Abnormal Blood Pressure _____	☐ Kidney Disease _____
☐ Rheumatic Fever _____	☐ Scarlet Fever _____	☐ Lung Disease _____	☐ Diabetes _____
☐ Asthma _____	☐ Tonsils _____	☐ Tuberculosis _____	☐ Gland Issue _____
☐ Epilepsy _____	☐ Nervous Disorders _____	☐ Broken Bones _____	☐ Strep Throat _____
☐ Operations _____	☐ Adenoids _____	☐ Measles _____	☐ Chicken Pox _____
☐ Ear Issue _____	☐ Malignant Hyperthermia _____		☐ Physical Deformity _____
☐ Other _____			

Is your child allergic to anything? Yes ☐ No ☐ *If so, describe*: _____

Does your child bruise easily or bleed profusely for a long period of time? Yes ☐ No ☐

Does your child have any blood disease? Yes ☐ No ☐

Is your child now taking any medications, or has she/he ever had:

☐ Penicillin _____	☐ Other Antibiotics _____	☐ Cortisone _____
☐ Local Anaesthesia _____	☐ General Anesthesia _____	☐ Other _____

Has your child had any unfavourable reaction to the above drugs? Yes ☐ No ☐

If so, describe: _____

Is there a history of any inherited diseases in the family? Yes ☐ No ☐

If so, describe: _____

Dental History

Has your child had previous dental care? Yes ☐ No ☐ If so, when: _____

Has she/he ever had unpleasant experience associated with dental treatment? Yes ☐ No ☐

If so, describe: _____

Has your child ever had an accident, injury or surgery about the mouth? Yes ☐ No ☐

If so, describe: _____

Is there a family history of any of the following?

☐ High Decay Rate	☐ Missing Teeth	☐ Clef Lip/Palate	☐ Tooth Deformity	☐ Extra Teeth
☐ Spaced Teeth	☐ Crooked Teeth	☐ Other: _____		

Does your child have any oral habits:

☐ Thumb Sucking	☐ Nail Biting	☐ Chewing (ie. Pencils)	☐ Finger Sucking
☐ Mouth Breathing	☐ Lip Biting	☐ Teeth Grinding	☐ Other: _____

Has your child ever had any orthodontic treatment? Yes ☐ No ☐

How often does your child brush his or her teeth: _____

Do you supervise your child while tooth brushing? Yes ☐ No ☐

Has your child ever received fluoride supplements in the diet or water supply? Yes ☐ No ☐

Were his or her teeth ever treated with decay-preventing topical fluoride? Yes ☐ No ☐

General Release

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

Parent / Legal Guardian Signature: _____