KIDS MEDICAL & DENTAL HISTORY FORM

All information completed on this form will remain strictly confidential. Please complete in **CAPITAL LETTERS.**

Surname		Given Names	Mast/Miss
Date of Birth			
Best Daytime contact Number (8am-5pm) Parent's Phone (Mobile)	☐ ☐	Home Address Postcode	
Email address (parents) (for annual, 6-monthly reminders)			
Emergency contact (please provide name and phone number):			
Parent / Guardian's Name:			

ALL APPOINTMENTS WILL BE CONFIRMED VIA SMS UNLESS SPECIFIED OTHERWISE

What is your preferred method for appointment IF NOT SMS? ☐ Email ☐ Phone call

Referral Information

☐ Internet/Website ☐ Signage ☐Other ☐ Newspaper ☐ Family / Friend: _____

☐ Patient (please provide name so that we can thank them) _____

DENTAL HISTORY

Is your Child experiencing any of the following dental problems? (please tick as many that applies)

☐ Sensitivity to hot or cold
☐ Staining of your teeth
☐ Sensitivity when eating
☐ Food trapping between your teeth
☐ Bleeding gums
☐ Grinding or clenching of your teeth
☐ Clicking/pain in the jaw joints
☐ Bad breath

What is the main purpose of your child's visit today?

_____

How long since your child's last dental visit? _____

Does dental treatment make your child nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

MEDICAL HISTORY

Name of your GP (if known):		Your Doctor's Phone No:	
Your Doctor's address:			

Has your child ever had any of the following? Please tick as many that apply:

❑ Anaemia	❑ Fainting
❑ Artificial joints	❑ Glaucoma
❑ Asthma	❑ Heart Disease
❑ Blood Disease	❑ Heart Murmur
❑ Cancer	❑ Hepatitis A, B, C
❑ Dizziness	❑ Kidney Disease
❑ Epilepsy	❑ Liver Disease
❑ Excessive Bleeding	❑ HIV/ AIDS
❑ Diabetes	❑ Osteoporosis

Has your child had any serious illnesses in the last 2 years? If yes, please provide more information.	
Is your child currently taking any medications or tablets regularly? If yes, please provide more information.	
Does your child have any allergies to Penicillin or other drugs? If yes, please provide more information.	

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures.
- From time to time we will send you newsletters and special offers, please let us know if you do not want to receive these.
- I understand that the practice requires as minimum 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee of $50.00 could be incurred if I fail to do so.
- I hereby consent to the use of any study models, x-rays, computer images and photographs at various dental seminars, lectures, and publications that the dentists may author.
- I am aware that payment is required on the day of treatment.

x_____ _____

Parent/Guardian Signature **Date of signature**