CONFIDENTIAL

Lyndhurst Dental Centre

Child Medical/Dental History (16 & under)

Our mission is to serve those who seek comprehensive dental care. Our commitment is to provide a modern facility with the latest equipment and technical skills. Our personalized service features thorough examinations, customized treatment plans and an emphasis on regular preventive care. Expect "quality care in a caring atmosphere".

Please fill in with the **patient's** information:

Family Name: _____ First Name & Initial: _____
Street Address: _____ City/Town: _____
Postal Code: _____ Telephones: Home ___-_____ Work ___-_____ Fax ___-_____
Cell ___-_____ E-Mail Address _____
When is it best to reach you? _____ Where is it easiest to reach you? _____
Would you be available for **short notice** appointments? Y N Place of work: _____
Student: Yes No If yes….Name of School: _____
Date of Birth: Day _____ Month _____ Year _____
Emergency Contact Name: _____ Emergency Contact Phone: _____
Emergency Contact Relationship to Patient: _____

For the safety of some of our patients who are highly allergic - please help us to maintain a peanut free - scent free ...environment - please no body scent, hair spray or cigarette smoking on day of your appt. Thank you for your co-operation!

We accept: Cash, Debit Card, Visa, Mastercard or Personal Cheque.

Without prior arrangement, payment is expected on the day of the appointment.

Our Office Team will be happy to discuss arrangements with you.

If you are unable to keep an appointment please give at least two working days notice.

Missed appointments and **late cancellations** may be subject to a $75.00 fee.

Dr. McGregor recommends providing you with an estimate before starting treatment.

Person responsible for Account (if different from Patient listed above)

Name: _____
Relationship to Patient: _____
Address: _____ Work Phone: _____-_____
Home Phone: _____

Do you have a Dental Insurance Plan? **Yes No**

If **Yes**:
Please read the accompanying letter explaining claim submission procedures.
Fill in the requested information. (Ask our Office Team, if you need assistance.)
Continue this form next page

If **No**:

Continue next page

We now need a fairly extensive **Medical History**

Why? Does it really relate to my child's teeth? Yes, it is all inter-related. We especially need to know if your child is taking any medications or if they have any limiting physical conditions. You can count on being asked if there is any change in your child's medical condition each and every time they visit the office. **It is for your child's health!**

Please circle yes or no, and add any information you feel might be useful.
Dr. McGregor will review the questionnaire with you and your child.

Is this your child's first visit to a dental office?…..…… Yes No
If no, name of their previous dentist_____
What did you like/not like about that dentist?_____
What is the main reason for coming to our office?_____
What are you looking for in a dentist?_____
Is your child nervous about having dental treatment?…….. Yes No
Has he/she ever had a bad experience in a dental office?……. Yes No
Has he/she been a patient in the hospital during the past two years?…… Yes No
Has he/she been under the care of a medical doctor in the past two years?…….. Yes No
Name & **location** of your child's medical doctor _____
How did you find out about Dr. McGregor's office?_____
Whom may we thank for referring you?_____
Has he/she taken any medicine or drugs in the past two years?…… Yes No
Has he/she had tonsils removed?…….. Yes No
Has he/she had adenoids removed?…….. Yes No
Has he/she had any surgeries in the past two years?……... Yes No
If yes, please list type and date_____

Please bring to the appointment **all prescriptions** and **over the counter medication & inhalers** here: (Vitamins, Herbals etc. are to be listed on Page 3)_____

_____

_____

Is he/she **allergic** to (i.e. itching, rash, and swelling of hands, feet or eyes), or ever reacted adversely to any of the following:

Aspirin	Codeine	Ibuprofen	Tylenol other pain pill not listed
Penicillin	Erythromycin	Dalacin C	Sulfa Drugs Other antibiotics not listed
Local Anaesthetic	General Anaesthetic	IV Sedation	Nitrous Oxide (Laughing gas)
Tranquilizers/Sedatives	Other medication not listed		
Latex Allergy			

Circle any of the following, which your **child has had, or has at present**.

Artificial Heart Valve	Mitral Valve Prolapse	Heart Surgery	Chronic Bronchitis Heart Disease
Heart murmur	Rheumatic fever	Scarlet fever	Congenital heart condition
Asthma (inhalers)	Cough	Cortisone medication	A.D.D. Tuberculosis
Hay fever	Sinus problems	Allergies/hives	Allergy to bee, wasp, yellow jacket stings
Carry EpiPen Y N	Kidney disease	Liver disease	Organ transplant _____

Diabetes Oral/Injectable insulin (Ave. readings _____)
AIDS Haemophilia Sickle Cell Anaemia Anaemia Yellow Jaundice
Blood transfusion Drug addiction Alcohol addiction AIDS positive serum Acid Reflux
Thyroid disease (thyroid meds_____) Hepatitis A Hepatitis B (serum)
Hepatitis C Smoke cigarettes-how many _____ Cold sores Genital herpes
Venereal disease Yeast infection Epilepsy or seizures Fainting spells Nervousness
Panic/Anxiety attacks Psychiatric treatment Cancer, type_____
Radiation therapy Chemotherapy Does your child attend the Cancer Clinic for follow up visits Y N
Any other medical conditions not listed above:_____

Does he/she use recreational street drugs?…… Yes No
If female, is she pregnant?……. Yes No
Is she taking birth control pills?…… Yes No

********Antibiotics may reduce the effectiveness of birth control pills. If these are prescribed for you, you must use an alternate method of birth control during the remainder of your cycle*********

Is he/she vegetarian? lacto/ovo/vegan…… Yes No
Is he/she on a special diet?…….. Yes No
Has he/she ever been anorexic/bulimic?……. Yes No
Vitamin, Mineral or Herbal Supplements?…….. Yes No
If yes, please list names and dosage taken daily_____

_____

_____

Is there something you would like to change/improve about his/her smile?…….. Yes No
What?_____
Is your child having any pain in his/her teeth or gums?…….. Yes No
Do you brush his/her teeth?…… Yes No
Do you floss his/her teeth?……. Yes No
How often?
Does/did anyone in your family have gum disease?…….. Yes No
Does he/she have bad breath?…….. Yes No
Do you brush his/her tongue?…….. Yes No
How often?_____
Do his/her gums bleed when you/they brush?…… Yes No
Do his/her gums bleed if/when you/they floss?…… Yes No
Are there places in between his/her teeth where floss gets caught or shreds?…… Yes No
If yes, where?_____
Are there places in between their teeth where foods gets stuck?…… Yes No
If yes, where (example, upper right back)?_____
Does he/she use mouthwash?…….. Yes No
If yes, does it contain alcohol? Yes No Not sure
Does he/she use a fluoride rinse?…….. Yes No
If yes, which one and how often?_____
Does he/she use a manual or power toothbrush?_____
Does he/she have any caps/crowns on their teeth?…… Yes No
Does he/she have any fixed bridgework?…….. Yes No
Do you hear any clicking, popping when he/she chews?…… Yes No
Does your child seem to stop breathing for short periods during the night?…… Yes No
Does your child snore?…… Yes No

Does your child wet the bed?……. Yes No
Does he/she sleep through the night?……... Yes No
Does your child seem cranky during the day?…… Yes No
Does he/she seem sleepy during the day?…… Yes No
Does he/she complain of headaches?……. Yes No
Does he/she breathe through his/her mouth or his/her nose?…….. Yes No
Does he/she grind or clench their teeth?…….. Yes No
If yes, during the day or when they are sleeping?_____
Has he/she ever worn a night guard or grinding appliance?…… Yes No
Over the last twelve-month period, how many ear infections has your child had?_____
Does he/she have tubes in his/her ears?…… Yes No
Has he/she had orthodontic treatment (braces)?…….. Yes No
Has he/she ever worn orthodontic appliances or retainers?……. Yes No
Does he/she play contact sports?……. Yes No
If yes, does he/she have an athletic protective mouthguard?…….. Yes No
If yes, was it custom made for their teeth?……. Yes No
Has he/she ever sustained any facial injuries (including childhood bicycle spills, falls, or a blow to the face/mouth….ect.)?…… Yes No
Has he/she ever fractured a facial bone?…… Yes No
Has he/she ever had head injury?…… Yes No
Does he/she have/see a chiropractor?……... Yes No
If yes, who?_____
If yes, when is your next visit?_____
Does he/she wear orthotics or any body supports, brace?…… Yes No
Has he/she ever had a root canal?…… Yes No
Do you think their mouth reflects their overall health, or that overall health (or lack of it) can affect the health of people's teeth, gums and bite?…….. Yes No

If you could have ***whatever you wished*** for in regard to your child's teeth, their Smile, their mouth etc…. what would that be?_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If my child's health changes, or if medications change, I will inform Dr. McGregor or a member of her staff at the next appointment.
I consent to the anonymous sharing of my child's clinical information for the purpose of education and discussion.

Date	Signature of patient Parent or Guardian if patient is under 18 years or if patient is physically or mentally unable to complete themselves.	Signature of Dentist