ALEXANDRIA MERIANO, B.Sc. D.D.S. M.S. F.R.C.D.(C.)
Paediatric Dentist — *Certified Specialist treating infants, children and adolescents.*

HEALTH HISTORY AND PATIENT INFORMATION

Patient's Name _____ Healthcard # _____

Address _____ City/Town _____ Postal Code _____

Birthdate _____ Sex: M F School _____ Grade _____

Mother's Name _____ Address _____
Phone _____ Employer _____ Bus. Phone _____

Father's Name _____ Address _____
Phone _____ Employer _____ Bus. Phone _____

Insurance Company _____ Group # _____ Certificate # _____

Bill account to: Father_____ Mother_____ Other_____

Is your child eligible for Provincial or Social Assistance? _____

Person to contact locally, other than parents, in case of emergency _____
Relationship to child _____ Phone _____ Bus. Phone _____

Child's Physician/Paediatrician _____ Phone _____

Pharmacy _____ Phone _____

Names and Ages of Siblings _____

What is your child most interested in? _____

Whom may we thank for referring you? _____

Name of Family Dentist _____ Phone _____

Reason for bringing your child in _____

_____

MEDICAL HISTORY	YES	NO
1. Does your child have a medical condition requiring regular checkups by their doctor?	Y	N
2. Is your child being treated by a physician at this time?	Y	N
3. Is your child taking any medicines at this time?	Y	N
specify: type _____ dose_____		
4. Has your child had any unfavourable reaction to drugs, including antibiotics and local anesthetics?	Y	N
specify: _____		
5. Does your child have asthma, hayfever, other allergies, hives, or skin rashes?	Y	N
specify: _____		
6. Has your child ever been hospitalized for illness or surgery?	Y	N
7. Does your child bleed for a long time following cuts, have frequent nosebleeds, or bruise easily?	Y	N
8. Have you ever been told by a physician that your child has a heart murmur?	Y	N
9. Is your child physically, mentally, or emotionally handicapped?	Y	N
explain: _____		
10. Are your child's immunizations up to date?	Y	N
11. Is there any reason to think that you or your child may have been exposed to, or is at risk for Hepatitis or HIV (AIDS) infection? If so, please discuss this with the dentist.		

(please turn the page)

Windsor Health Centre, Plaza 400, 1720 Howard Avenue, Suite 358, Windsor, Ontario N8X 5A6
(519) 977-0325

12. Has your child ever been diagnosed as having, or been treated for any of the following conditions? (please circle):

Autism	Eye Problems	Liver/Hepatitis	Scarlet Fever
Blood Disorder	Endocrine Glands	Malignant Hyperthermia	Skin Problems
Cancer/Leukemia	Ears/Nose/Throat	Measles/Mumps	Speech Problems
Cerebral Palsy	Fainting Spells	Muscular Problems	Spina Bifida
Chicken Pox	Gastrointestinal (stomach)	Nervous System/Brain	Syndrome_____
Cleft Lip/Palate	Heart Disaese	Nutritional Deficiency	Tonsils/Adenoids
Diabetes	Herpes/Cold Sores	Orthopaedic/Skeletal	Tuberculosis
Epilepsy/Seizures	Jaundice	Respiratory Disease	Other_____
Eating Disorder	Kidney/Bladder	Rheumatic Fever	_____

DENTAL HISTORY

13. Has your child ever been seen by a dentist before? Y N
14. Is your child receiving (or ever received) fluoride in any form? Y N
    specify: _____
15. How often does your child brush his/her teeth? _____ times a day.
16. Do you assist your child with their oral hygiene? Y N
17. What type of toothpaste does your child use? _____
18. What is your child's source of drinking water? City supply _____ Other _____
19. At what age did your child stop bottle/breast feeding? _____
20. Has your child ever had trauma or injury to the face, jaws, or teeth? Y N
    explain: _____
21. Do you or your child think there is something wrong with his/her teeth, such as crooked, chipped, discoloured, decayed, etc.? Y N
    _____
22. Does your child have any oral habits, such as thumbsucking, finger sucking, grinding of teeth, lip biting, or nail biting? Y N
    _____

BEHAVIOURAL BACKGROUND

23. Do you consider your child to be: (Please check one)
    Advanced in learning Progressing normally Slow learner

24. How do you think your child has reacted to medical procedures?
    Very well Well Poorly Very poorly

25. How would you rate your own anxiety (nervousness) at this moment:
    High Moderately high Moderately low Low

26. How well do you expect your child to accept dental treatment?
    Very well Well Poorly Very poorly

_____ _____ _____

Signature of person completing form Relationship to patient Date

Do NOT write below this line

SUMMARY:

Medical Alert _____

Precautionary measures for dental care _____

SBE recommendations _____

_____