Dental as anything

New Child Medical History Form

For children up to 12 years

Welcome to Dental as Anything where we provide individualized care for infants, toddlers, children and teens. Our focus is on prevention and early management of dental disease. We are honoured that you have entrusted your child's care to us. We take great pride in providing a comfortable experience for children and their families. Should you have any special requests, please inform us and we will do our best to accommodate you.

How did you find us? (please tick)			
Professional recommendation	Referred by family of friend	Signage	Facebook
GP referral	Staff referral	Live in the area	Google
Practice Website	Patient referral		

Other: _____

Who may we thank for referring you? _____

Tell us about your child:

Surname*: _____ Given Name*: _____

Preferred Name*: _____ Date of Birth*: / / Age: _____

Siblings we treat: _____

School: _____ Grade: _____

Home Address*: _____ Suburb*: _____ Postcode*: _____

Billing Address (if different): _____ Suburb: _____ Postcode: _____

Phone (Home): _____ Mobile: _____

Favourite Movie: _____ Favourite song/singer _____

Favourite activity: _____

Name of Private Health Fund (if any): _____ Position Number on card: _____

Parents	
Name*	Name
Best contact number*	Best contact number
Email*	Email*

Who is accompanying your child today?

Name: _____ Relationship _____

Do you have legal custody of your child? ☐ Yes ☐ No

Medical History

Please indicate your child's current general health (please tick) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your general practitioner: _____ Suburb: _____

Has your child ever had any of the following?(Please tick)

- ☐ Kidney or liver conditions
- ☐ Disabilities / special needs
- ☐ Rheumatic / scarlet fever
- ☐ Hepatitis
- ☐ Allergies to drugs
- ☐ ADD / ADHD
- ☐ Blood disorders
- ☐ Cancer
- ☐ Asthma
- ☐ Epilepsy
- ☐ Food allergies
- ☐ Hospital stay
- ☐ Sickle cell disease
- ☐ Heart disease or murmur
- ☐ Congenital birth defects
- ☐ Tuberculosis
- ☐ Abnormal bleeding
- ☐ Diabetes
- ☐ Operations
- ☐ HIV+ / AIDS
- ☐ Autism
- ☐ Latex allergy
- ☐ Hearing impairment
- ☐ Other

Others (Please specify): _____

Have you or anyone in your household returned from overseas travel in the last 10 days? ☐ Yes ☐ No

Have you been hospitalised in the last 12 months? ☐ Yes ☐ No

Please list all medication your child is currently taking _____

_____

Child's allergies _____

Dental History

Is this your child's first visit to a dentist? ☐ Yes ☐ No If no, how long since the last visit? _____

Previous dentist's name _____

Any X-rays taken at previous dental visits? ☐ Yes ☐ No Any injuries to the teeth, face or mouth? ☐ Yes ☐ No

If yes, please explain _____

Family history of dental problems? ☐ Yes ☐ No

If yes, please explain _____

Why did you bring your child to the dentist today? _____

Do you have any dental concerns or questions? _____

Have previous dental visits been positive or negative? Why? _____

Do any of the following apply to your child

☐ Frequent snacking ☐ Sleeping with a bottle ☐ Pacifier use

☐ Breast-feeding ☐ Tooth grinding ☐ Thumb sucking

Cups per day of _____ **Milk** _____ **Juice** _____ **Fizzy drinks** _____

Cups per night of _____ **Milk** _____ **Juice** _____ **Fizzy drinks** _____

Is there anything we can do to help make your child more comfortable? _____

_____

Dental care at home

Brushes his or her own teeth? ☐ Yes ☐ No How often a day? _____

Difficulty brushing his or her teeth? ☐ Yes ☐ No Does your child use xylitol products? ☐ Yes ☐ No

Does your child floss daily? ☐ Yes ☐ No Does your child use fluoride toothpaste? ☐ Yes ☐ No

Do you floss your child's teeth? ☐ Yes ☐ No Is your child taking fluoride supplements? ☐ Yes ☐ No

Is your child able to spit? ☐ Yes ☐ No

Consent for Treatment

- ❑ I am happy to receive SMS and Email communication from Dental as Anything for critical or pertinent appointment reminders and any other information that pertains to dental awareness, health fund or government changes.
- ❑ I hereby consent to dental treatment deemed necessary by the dentists and agreed by my verbal consent beforehand to be carried out. I understand that it will be discussed with me before any staff takes x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.
- ❑ I agree to be responsible for the payment of all services rendered on my behalf and on behalf of my dependants. I understand that payments are due at the time of service.

Relationship to child _____ Signature: _____ Date*:_____

(Parent/Guardian to sign)